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Phone 830 249-3242 Fax 830 249-7356

Medical History

Name: _____ Date : _____
Date of birth: _____ Sex: M / F Height: _____ Weight:_____

For the following questions, please circle yes or no. Your answers are for our records only and will be kept confidential.

Yes No Are you taking any prescription or non-prescription medication (including diet pills, vitamins, homeopathic or natural remedies)?
If so, please list: _____
_____
_____

Yes No Are you in good health?.....
Yes No Has there been any change in your health in the past year?…….....
Your last physical exam was on _____/ _____/ _____
Yes No Are you now under the care of a physician?…….....
If so, for what condition? _____
The name and address of your physician: _____
_____

Are you allergic or have you had a reaction to:
Yes No Local anesthetics.....…….....
Yes No Penicillin, Amoxicillin.....…….
Yes No Keflex, Cephalexin.....…….
Yes No Erythromycin, Zithromax.....……...
Yes No Tetracycline, Doxycycline.....……..
Yes No Clindamycin, Cleocin.....…….
Yes No Sulfa drugs.....……..
Yes No Barbiturates or sleeping pills.....……..
Yes No Codeine or other narcotics.....……..
Yes No Aspirin.....……
Yes No Latex or rubber products.....…….
Other.....……...

Yes No Have you had any serious illness, operation or hospitalization within the past 5 years?
If so, please explain: ……
Yes No Have you had an artificial joint replacement (knee, hip, shoulder, etc.)?..……...
Yes No Are you taking or have you ever taken bisphosphonates (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)?.....…….....
Do you have or have you had any of the following diseases or problems?
Yes No Damaged heart valves, artificial valves or congenital heart disease……....
Yes No Rheumatic heart disease or heart murmur…….....
Yes No Previous heart infection…….....
Yes No High / low blood pressure……....
Yes No Irregular heart beat …….....
Yes No Heart attack, angina, stroke, arteriosclerosis or any other heart condition…….....
Yes No Heart surgery……....
Yes No Anemia…….....

Over, Please

Yes No Blood transfusion…………………………………………………………………………......
Yes No Abnormal bleeding……………………………………………………………………......
Yes No Asthma or hay fever …………………………………………………………………….....
Yes No Respiratory problems, emphysema, tuberculosis ……………………………………….....
Yes No Diabetes …………………………………………………………………………………...
Yes No Hepatitis, jaundice or liver disease …………………………………………………......
Yes No Kidney trouble ………………………………………………………………………......
Yes No Fainting spells or seizures, epilepsy……………………………………………………....
Yes No Thyroid problems …………………………………………………………………….....
Yes No Stomach ulcer or hyperacidity ………………………………………………………......
Yes No Eye or retinal problems …………………………………………………………………...
Yes No Osteoporosis ……………………………………………………………………………....
Yes No Arthritis ……………………………………………………………………………….....
Yes No Cancer ………………………………………………………………………………......
Yes No Any disease, drug or transplant operation that has depressed your immune system ……………...
Yes No Have you ever had treatment for a tumor or growth? ………………………………….........
Yes No Have you had radiation therapy to the head, neck or jaws? …………………………………....
Yes No Have you had any serious trouble associated with previous dental treatment? ………………......
If so, please explain: ____

Yes No Do you smoke or chew tobacco? ………………………………………………………….....
Yes No Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide for you? ………………………………………………………........................
Yes No Do you have any other condition or disease you think the doctor should know about? ……………....
If so, please explain: ____

Women:
Yes No Are you taking birth control pills? ……………………………………………………………...
Yes No Are you pregnant or trying to become pregnant? ……………………………………………....
Yes No Are you nursing? ……………………………………………………………………………....

I have read and understand the above. Any questions I had about this form have been answered. I understand it is my responsibility to fill out the form correctly and completely.

Patient's signature:____Date:______________

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Please list any changes in your health and/or medication: _______________________________________
____
Patient's signature:____Date:______________

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