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West Chester, OH 45069
(513) 860-3660

MEDICAL HISTORY

Do you have any current health problems? Yes No
Please describe _____

Are you currently under the care of a physician? Yes No
Please describe _____
Physician's name and phone _____

Are you currently taking any medications or supplements? Yes No
Medication_____dose_____
Medication_____dose_____
Medication_____dose_____

Have you been in the hospital, had a serious illness, or major surgery? Yes No
_____
_____

Have you had any of the following:

Anemia
Arthritis
Artificial joints (hip, knee)
Asthma
Blood disorders
Cancer
Chemotherapy
Diabetes
Digestive disorders (gastric reflux)
Drug Dependency
Emphysema
Epilepsy, Seizures
Fainting, dizziness
Fever blisters
Cold sores
Glaucoma
Hay fever
Headaches
Heart attack
Heart disease
Heart murmur
Heart surgery
Hemophilia
Hepatitis (type__)
High blood pressure
Low blood pressure
HIV-AIDS
Kidney disease
Liver disease
Neurologic problems
Nervousness
Osteoporosis, osteopenia
Pacemaker
Pain in jaw joints
Radiation treatment
Sinus problems
Sleeping problems
sleep apnea
snoring
Stroke
Tuberculosis
Ulcers

Are you allergic to or reacted adversely to any of the following:

Any metals
Aspirin
Codeine
Erythomycin
Ibuprofen
Latex
Local anesthetic
Nitrous oxide
Penicillin

Are you aware of being allergic to any other medications or substances? _____

_____

Any other medical or dental information you feel we should know? _____

_____

The undersigned authorizes the dentist to take necessary x-rays, study models, photographs, or other diagnostic aids deemed appropriate to make a thorough diagnosis. I also authorize the dentist to perform all forms of treatment that may be indicated. I understand there are certain risks with the use of anesthetic agents, and I understand that I am responsible for payment of dental services for me and my dependents. I will also assign insurance benefits to the dentist.

Patient signature_____Date_____

Creating healthy beautiful smiles in a family environment