Patient Medical Information

Erica's Mobile Smiles

6/26/2013

Title _____ **First Name** _____

Surname _____

Date of Birth _____ **Marital Status** _____ **Occupation** _____

Address _____

_____ **Postal Code** _____

Tel Contact _____ _____ _____

Are you being treated for any medical condition at the present or have you been treated within the last year?
Yes ☐ No ☐ Not Sure ☐

If so, why? _____

When was your last medical check-up? _____

Has there been any change in your general health in the last year?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain: _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
Yes ☐ No ☐ Not Sure ☐

If yes, please list: _____

Do you have any allergies? If you answered yes, please list using the categories below:
Yes ☐ No ☐ Not Sure ☐

Medications _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had a peculiar or adverse reaction to any medicines or injections?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have or have you ever had asthma?
Yes ☐ No ☐ Not Sure ☐

Do you have or have you ever had any heart or blood pressure problems?
Yes ☐ No ☐ Not Sure ☐

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
Yes ☐ No ☐ Not Sure ☐

Have you ever had hepatitis, jaundice or liver disease?
Yes ☐ No ☐ Not Sure ☐

Do you have a prosthetic or artificial joint?
Yes ☐ No ☐ Not Sure ☐

Do you have a bleeding problem or bleeding disorder?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Have you ever been hospitalized for any illnesses or operations?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
Yes ☐ No ☐ Not Sure ☐

Do you have any of the following? Please Check

☐ Alzheimers	☐ Epilepsy or Seizures	☐ Lung Disease	☐ Steroid Therapy
☐ Angina	☐ Fibromyalgia	☐ Lupus	☐ Stomach Ulcers
☐ Anemia	☐ Thyroid Disorder	☐ Migraines	☐ Stroke
☐ Arthritis	☐ Head/Neck Injury	☐ Mitral Valve Prolapse	☐ Thrush
☐ BloodTransfusion	☐ Heart Attack	☐ Osteoporosis Medications (e.g. Fosamax, Actonel)	☐ TMJ Disorder
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Tuberculosis
☐ Chest Pain	☐ High/Low Blood Pressure	☐ Parkinsons Disease	☐ Sexually Transmitted Infection
☐ Diabetes	☐ Hodgkins Disease	☐ Radiation/Chemotherapy	
☐ Drug / Alcohol Dependency	☐ Hypo/Hyperglycemia	☐ Rheumatic Fever	
☐ Emphysema	☐ Kidney Disease	☐ Shortness of Breath	

Are there any conditions or diseases not listed above that you have or have had?

Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you smoke or chew tobacco products?

Yes ☐ No ☐ Not Sure ☐

Are you nervous during dental treatment?

Yes ☐ No ☐ Not Sure ☐

For women only: Are you pregnant?

For women only: are you breastfeeding?

Doctor _____ **Tel** _____

Address _____

The information I have given above is true to the best of my knowledge.

Patient Signature _____ **Date** _____