Sherman Oaks Dental - Medical Form

PATIENT NAME: DATE :

If you answered ***yes*** please explain:

Are you under a physician's care now? ❑ Yes ❑ No _____
Are you taking any medications, pills or drugs? ❑ Yes ❑ No _____

_____

_____

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No _____
Have you ever had a serious head or neck injury? ❑ Yes ❑ No _____
Do you take, or have you taken, Pen-Fen or Redux? ❑ Yes ❑ No _____
Are you on a special diet? ❑ Yes ❑ No _____
Do you use controlled substances? ❑ Yes ❑ No _____
Do you use tobacco? ❑ Yes ❑ No _____

Women: Are you ❑ Pregnant / trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑Aspirin ❑Penicillin ❑Codeine ❑Acrylic ❑Metal ❑Latex ❑ Local Anesthetics ❑Other _____

Do you have, or have you had any of the following?

❑	AIDS/HIV positive	❑	Chest pains	❑	Frequent Headaches	❑	Irregular Heart Beat	❑	Scarlet Fever
❑	Alzheimer's Disease	❑	Cold Sores/Fever Blisters	❑	Genital Herpes	❑	Kidney Problems	❑	Shingles
❑	Anaphylaxis	❑	Congenital Heart Disease	❑	Glaucoma	❑	Leukemia	❑	Sickle Cell Disease
❑	Anemia	❑	Convulsions	❑	Hay Fever	❑	Liver Disease	❑	Sinus Trouble
❑	Angina	❑	Cortisone Medicine	❑	Heat Attack/Failure	❑	Low Blood Pressure	❑	Spina Bifida
❑	Arthritis/Gout	❑	Diabetes	❑	Heart Murmur*	❑	Lung Disease	❑	Stomach/Intestinal Disease
❑	Artificial Heart Valve	❑	Drug Addiction	❑	Heart Pace Maker*	❑	Mitral Valve Prolapse*	❑	Stroke
❑	Artificial Joint	❑	Easily Winded	❑	Heart Trouble/Disease	❑	Pain in Jaw Joints	❑	Swelling of Limbs
❑	Asthma	❑	Emphysema	❑	Hemophilia	❑	Parathyroid Disease	❑	Thyroid Disease
❑	Blood Disease	❑	Epilepsy or Seizures	❑	Hepatitis A	❑	Psychiatric Care	❑	Tonsillitis
❑	Blood Transfusion	❑	Excessive Bleeding	❑	Hepatitis B or C	❑	Radiation Treatments	❑	Tuberculosis
❑	Breathing Problem	❑	Excessive Thirst	❑	Herpes	❑	Recent Weight Loss	❑	Tumors or Growths
❑	Bruise Easily	❑	Fainting or Dizzy Spells	❑	High Blood Pressure	❑	Renal Dialysis	❑	Ulcers
❑	Cancer	❑	Frequent Cough	❑	Hives or Rash	❑	Rheumatic Fever*	❑	Venereal Disease
❑	Chemotherapy	❑	Frequent Diarrhea	❑	Hypoglycemia	❑	Rheumatism	❑	Yellow Jaundice

** Condition may require medication*

Have you ever had any serious illness not listed above? ❑ YES ❑ NO _____

*If **YES** please explain*

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN Today's Date

(Please Complete Other Side)