



# A WINNING SMILE DENTAL CENTER

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## MEDICAL HISTORY

Name \_\_\_\_\_

Do you have any current health problems? Yes No

Are you under a physician's care at present? Yes No

If so, for what? \_\_\_\_\_

What medications are you currently taking:  
including prescriptions, over the counter, or aspirin?

\_\_\_\_\_ Dosage \_\_\_\_\_ For What \_\_\_\_\_

\_\_\_\_\_ Dosage \_\_\_\_\_ For What \_\_\_\_\_

Do you smoke? Yes No Females: Do you take contraceptives? Yes No

Females: Are you pregnant? Yes No If yes, what month? \_\_\_\_\_

Circle any of the following you have had or presently have:

- |                            |                       |                          |
|----------------------------|-----------------------|--------------------------|
| Heart or Artery disease    | A.I.D.S or HIV+       | Bruising problems        |
| Angina pectoris/chest pain | Hepatitis             | Emphysema                |
| High blood pressure        | Respiratory problems  | Tuberculosis             |
| Scarlet fever              | Difficulty breathing  | Shingles                 |
| Heart murmur               | Liver disease         | Asthma                   |
| Rheumatic fever            | Sinus trouble         | Cosmetic surgery         |
| Congenital heart lesions   | Drug addiction        | Ulcers/stomach disorders |
| Mitral valve prolapse      | Bleeding problems     | Diabetes/hypoglycemia    |
| Artificial heart valve     | Fever blisters        | Thyroid problems         |
| Artificial joints          | Epilepsy or Seizures  | Radiation treatment/     |
| Pacemaker                  | Nervous problems      | Chemotherapy             |
| Heart surgery              | Psychiatric treatment | Arthritis/Rheumatism     |
| Anemia                     | Glaucoma              | Steroid medication       |
| Stroke                     | Cancer or Leukemia    | Alcoholism               |
| Kidney trouble             | Veneral disease       |                          |

Are you allergic to or have reacted to:

- |               |                   |                           |
|---------------|-------------------|---------------------------|
| Aspirin       | Local anesthetics | Penicillin or Sulfa drugs |
| Nitrous oxide | Codeine           | Erythromycin              |

Are you allergic to any other substances? \_\_\_\_\_

Is there any other medical information I should know about? \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Signed \_\_\_\_\_

Must be 18 years or older

Date