Medical History for Gentle Family Dentistry

Physician's Name:________________________

Physician's Phone #:__________________________

Prescription or Non Prescription Medications:

____________________________________   ___________________________________

____________________________________   ___________________________________

____________________________________   ___________________________________

____________________________________   ___________________________________

Allergies: (Circle if yes)

Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin
Dental Anesthetics	Latex	Tetracycline

Other:____

Miscellaneous:

Do you smoke: Y N   Height: _________

Weight:___________ lbs.|

For Women Only:

Are you taking birth control pills? Y N

Are you pregnant? Y N If yes, # of weeks: ________________

Are you nursing? Y N

Conditions: (Circle if yes)

High Blood Pressure	Blood Thinners	Thyroid Problems
Heart Attack	Hemophilia	HIV/AIDS

Conditions continued: (Circle if yes)

Stroke	Sickle Cell Disease	Hepatitis A,B or C
Heart Surgery	Anemia	Tuberculosis
Pace Maker	Diabetes	Alcohol Abuse
Angina Pectoris	Artificial joints, heart valves	Drug Abuse
Asthma/Emphysema	Arthritis	Pain in Jaw Joints
Bisphosphonate for Cancer	Allergies	Kidney Problems
Cancer-chemotherapy	Epilepsy or Seizures	Liver Disease
Radiation Therapy	Psychiatric Problems	

Do you have other conditions or problems not covered above?

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Signature:____

Date:___________________________________