

Avondale Dental Center Medical History

Patient name: _____ Date: _____

Medical Physician's name: _____ Physician's Ph # _____

Please Circle

Yes No 1. Has there been any change in your general health in the last year? _____

Yes No 2. Have you been a patient in the hospital during the past five years? _____

Yes No 3. Have you been under the care of a physician during the past two years? _____

Yes No 4. Have you taken any medication or drugs during the past two years? _____

Yes No 5. Are you now taking any medication, drugs or pills including supplements and nonprescription drugs?

If yes, please list _____

Yes No 6. Do you have or have you had a problem with alcohol or drugs?

Yes No 7. Have you ever taken Phenfen (Redux or Pondamin)?

Yes No 8. *Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? (check if applicable)...*

Penicillin/antibiotics _____

Drugs/medications _____

Local anesthetics _____

Latex/rubber _____

Metals _____

Other _____

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

(Please circle if any of the following apply)

Heart ailment	Arteriosclerosis	Heart Murmur/Defect	Mitral Valve Prolapse
Rheumatic Fever	Catheter	Artificial Joint or Valve	High or Low Blood Pressure
Chest Pain/Angina	Pacemaker	Steroids/Cortisone	Drug addiction
Bruise easily	Blood transfusion	Hemophilia	Anemia or Blood disorder
Sickle Cell Anemia	Stroke	Abnormal bleeding	Fainting/Dizziness
Kidney disease	Thyroid problems	Diabetes (or family history)	Hepatitis/Liver disease
Chronic cough	Arthritis	Lumps/Swollen Glands	Tuberculosis/Lung problems
Ulcers	Sinus trouble	Allergies or Hives	HIV positive or AIDS
Asthma	Cancer or Tumor	Venereal Disease	Radiation/Chemotherapy
Herpes or Cold sores	Alcoholism	Emphysema	Neurological condition
Epilepsy/Seizures	Glaucoma	Frequent headaches	

Do you have any disease, condition, or problem that may interfere with dental treatment that is not listed above?

FOR WOMEN:

1. Are you pregnant? Yes No

2. Are you nursing? Yes No

3. Are you taking birth control pills? Yes No

Signature of Patient, Parent or Guardian _____