Gentle Touch Smiles Medical History

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding / Hemophilia
Y	N	ADD/ADHD
Y	N	Aids/HIV
Y	N	Alcohol/Drug Abuse
Y	N	Anemia
Y	N	Arthritis
Y	N	Artificial Bones/Joints/Valves
Y	N	Asthma
Y	N	Blood transfusion
Y	N	Cancer/Chemotherapy
Y	N	Chicken Pox
Y	N	Colitis
Y	N	Congenital Heart Defect
Y	N	Convulsions
Y	N	Diabetes
Y	N	Difficulty Breathing
Y	N	Emphysema
Y	N	Epilepsy
Y	N	Exposed to HIV, but Neg.
Y	N	Fainting spells
Y	N	Frequent Headaches
Y	N	Glaucoma
Y	N	Handicaps/Disabilities
Y	N	Hay Fever
Y	N	Heart attack
Y	N	Heart Murmur
Y	N	Heart surgery
Y	N	Hepatitis
Y	N	Herpes
Y	N	High Blood Pressure
Y	N	HIV
Y	N	Hospitalized for any reason
Y	N	Kidney Problems
Y	N	Liver Problems
Y	N	Low blood pressure
Y	N	Lupus
Y	N	Measles
Y	N	Mitral Valve Prolapse
Y	N	Mononucleosis
Y	N	Pace maker
Y	N	Prosthetics
Y	N	Psychiatric Problems
Y	N	Radiation treatment
Y	N	Rheumatic/Scarlet fever
Y	N	Seizures
Y	N	Shingles
Y	N	Sickle Cell Disease/Traits
Y	N	Sinus problems
Y	N	Stroke
Y	N	Thyroid Problems
Y	N	Tuberculosis (TB)
Y	N	Ulcers
Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:_____

_____

_____

Do you have a Primary Care Physician? ◯ Yes ◯ No

Physician Name_____

Physician Phone_____

Are the child's immunizations current? ◯ Yes ◯ No

Please list all prescription/over the counter or herbal supplement drugs that you are currently taking:_____

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Codeine
Y	N	Erythromycin	Y	N	Dental Anesthetics
Y	N	Latex	Y	N	Jewelry/Metals
Y	N	Penicillin	Y	N	Tetracycline
Y	N	Plastics	Y	N	Other

Please list any other drugs/materials that you are allergic to:_____

_____

Has the patient ever taken any diet pills such as Phen-Fen? (Also known as Redux or Pondimin) If so, when?

_____

Is the patient currently in pain? ◯ No ◯ Yes (explain)
Left Right Upper Lower

Does the patient require antibiotics before dental treatment? ◯ Yes ◯ No

Women:

Are you pregnant? ◯ Yes, week#_____ ◯ No

Are you nursing? ◯ Yes ◯ No

Birth control? ◯ Yes _____ ◯ No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform the necessary dental services I/my child may need.

Patient/Parent/Guardian Signature **Date**

OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian and patient named herein

_____

Provider Signature Date

_____

Provider Signature Date

◯ DEMO____ ◯ SCANNED____ ◯ NEW ◯ MED HX >2yrs