ART CITY DENTAL

ROBERT N. PERKINS D.M.D.

MEDICAL HISTORY

Patient's Name _____ Date of Birth _____

Physician's Name _____ Phone _____

Please answer the following questions as completely as possible (check "YES" or "NO")

Do you consider yourself to be in good health? YES NO

Are you now or have you been under a physician's care within the past year? YES NO

If yes, specify condition being treated _____

Do you take any medications, including birth control pills? YES NO

Please specify name and purpose of medications _____

Do you have or have you ever had any heart or blood problems? YES NO

Have you ever been told that you have a heart murmur? YES NO

Do you require antibiotic premedication for a heart condition, artificial valve or artificial joint? YES NO

Do you have or have you ever had high blood pressure? YES NO

Do you Bruise or bleed easily? YES NO

Have you ever been diagnosed as being HIV positive or having AIDS? YES NO

Have you ever had hepatitis or liver disease? YES NO

Have you ever had (check if yes): ☐ rheumatic fever; ☐ asthma; ☐ any blood disorder; ☐ diabetes;
☐ rheumatism; ☐ arthritis; ☐ tuberculosis; ☐ venereal disease; ☐ heart attack; ☐ kidney disease;
☐ immune system disorders; ☐ other disease (please specify) _____

Have you ever had an unusual reaction or are you allergic to any of the following drugs (check if yes):
☐ Penicillin; ☐ aspirin; ☐ Acetaminophen; ☐ Ibuprofen; ☐ Codeine; ☐ Barbiturates; ☐ Sulfa Drugs;
☐ Other _____

Are you subject to fainting? YES NO

Have you ever had any severe reaction to dental treatment or local anesthetics? YES NO

Are you allergic to any local anesthetic? YES NO

Are you allergic to any metals? YES NO

Do you have any other allergies? If yes, please describe: _____

Have you ever had a nervous breakdown or undergone psychiatric treatment? YES NO

Have you ever received counseling for excessive use of alcohol and/or prescription drugs? YES NO

Women: Are you pregnant? YES NO

Are you now in pain? YES NO

How long ago did you last see a dentist? _____

Who was your previous dentist? _____

Do you think that your teeth are affecting your general health in any way? YES NO

Do you have or have you ever had bleeding or sensitive gums? YES NO

I HEREBY CERTIFY THAT THE ANSWERSTO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BES OF MY KNOWLEDGE. SINCE A CHANGE F MEDICAL CONDITION OF MEDICATOINS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT VISIT.

_____ _____

(Patient, Legal Guardian or Authorized Agent) Date

Medical History Update: Date	Dr. Initials	Pt. Initials