

The Dentists on Jones Road

In the yellow house

Medical Health History

Name: _____ Date: _____
 General Health: Excellent Good Fair Poor Date of last Physical: _____
 Name & Phone # of Physician: _____
 Please list all medications you are presently taking: _____

Have you been hospitalized or under a doctor's care during the past 3 years? Yes No

Has a doctor told you that you need antibiotics to pre-medicated for dental work? Yes No

Please check all of the following you have had or have now:

<input type="radio"/> Heart Disease or Surgery	<input type="radio"/> Thyroid Problems	<input type="radio"/> AIDS/HIV
<input type="radio"/> High/Low Blood Pressure (which)	<input type="radio"/> Epilepsy/Seizures	<input type="radio"/> Hepatitis Type _____
<input type="radio"/> Mitral Valve Prolapse	<input type="radio"/> Fainting/Dizziness	<input type="radio"/> Cold Sores
<input type="radio"/> Heart Murmur	<input type="radio"/> Cancer/Tumor	<input type="radio"/> Asthma/Cough
<input type="radio"/> Congenital Heart Defects	<input type="radio"/> Radiation Treatment	<input type="radio"/> Sinus Problems
<input type="radio"/> Pacemaker	<input type="radio"/> Artificial Joint	<input type="radio"/> Headaches
<input type="radio"/> Angina	<input type="radio"/> Arthritis	<input type="radio"/> Anemia
<input type="radio"/> Stroke	<input type="radio"/> Stomach Problems/Ulcers	<input type="radio"/> Smoke/Tobacco
<input type="radio"/> Diabetes	<input type="radio"/> Kidney Problems	<input type="radio"/> Blood Thinners

Do you have any disease, mental or health condition or problem not listed? _____

Are you **ALLERGIC** to Penicillin Codeine Local Anesthetic (injected) Other _____

Are you subject to prolonged bleeding? Yes No

Are you sensitive to any Metals Latex?

Have you ever taken Fosomax, Zometa, Aredia or any other oral or intravenous treatment for bone tumors, excessive calcium in your blood, or osteoporosis? Yes No

Are you taking any anti-depressants or anti psychotic medications Yes No

Women:

Are you Pregnant? Yes No

COMMENTS:

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

ANESTHESIA	MEDICAL ALERT
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