annette williamson dds & associates
SMILES ON BROADWAY

MEDICAL HISTORY

PATIENT'S NAME _____ **DATE OF BIRTH** _____

Are you under a physician's care now? ☐ Yes ☐ No If yes, please describe _____

Been hospitalized or had major surgery? ☐ Yes ☐ No If yes, please describe _____

Had serious head or neck injury? ☐ Yes ☐ No If yes, please describe _____

Taking any medications, pills or drugs? ☐ Yes ☐ No If yes, please describe _____

Take or have taken Phen-Fen or Redux? ☐ Yes ☐ No If yes, please describe _____

Have taken Fosamax, Boniva, Actonel or medications containing bisphosphonates? ☐ Yes ☐ No If yes, please describe _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Pregnant or trying to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Penicillin ☐ Erythromycin ☐ Local Anesthetic ☐ Codeine ☐ Aspirin ☐ Hydrocodone ☐ Sulfa ☐ Latex

Allergies to other materials / medications? ☐ Yes ☐ No If yes, please describe _____

Use controlled substances? ☐ Yes ☐ No If yes, please describe _____

Other? ☐ Yes ☐ No If yes, please describe _____

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

AIDS/HIV positive ☐ Yes ☐ No	Cortisone medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation treatment ☐ Yes ☐ No
Alzheimer's ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Recent weight loss ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Renal dialysis ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatic fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High blood pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Arthritis / Gout ☐ Yes ☐ No	Epilepsy / seizures ☐ Yes ☐ No	High cholesterol ☐ Yes ☐ No	Scarlet fever ☐ Yes ☐ No
Artificial heart valve ☐ Yes ☐ No	Excessive bleeding ☐ Yes ☐ No	Hives / rash ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial joint ☐ Yes ☐ No	Excessive thirst ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle cell disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting / dizziness ☐ Yes ☐ No	Irregular heartbeat ☐ Yes ☐ No	Sinus trouble ☐ Yes ☐ No
Blood disease ☐ Yes ☐ No	Frequent cough ☐ Yes ☐ No	Kidney problems ☐ Yes ☐ No	Spina bifida ☐ Yes ☐ No
Blood transfusion ☐ Yes ☐ No	Frequent diarrhea ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach / Intestinal ☐ Yes ☐ No
Breathing problems ☐ Yes ☐ No	Frequent headaches ☐ Yes ☐ No	Liver disease ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Bruise easily ☐ Yes ☐ No	Genital herpes ☐ Yes ☐ No	Low blood pressure ☐ Yes ☐ No	Swelling of limbs ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Lung disease ☐ Yes ☐ No	Thyroid disease ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay fever ☐ Yes ☐ No	Mitral valve prolapse ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chest pains ☐ Yes ☐ No	Heart attack / failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cold sores / blisters ☐ Yes ☐ No	Heart murmur ☐ Yes ☐ No	Pain in jaw joints ☐ Yes ☐ No	Tumors / growths ☐ Yes ☐ No
Congenital heart ☐ Yes ☐ No	Heart pacemaker ☐ Yes ☐ No	Parathyroid disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart disease ☐ Yes ☐ No	Psychiatric care ☐ Yes ☐ No	Venereal disease ☐ Yes ☐ No
Yellow jaundice ☐ Yes ☐ No			

Ever had any serious illness not listed? ☐ Yes ☐ No If yes, please describe _____

I have reviewed the information on this medical history and it is accurate to the best of my knowledge. I understand this information will be used by Smiles on Broadway to determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature _____ Date _____

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219.663.4200

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