SHERRY DENTAL PC

MEDICAL HISTORY

Patient Name ______________________________ Birthdate ______________________

Physician's Name ______________________________ Phone: ______________________

Heart Physician/Surgeon's Name ______________________________ Phone: ______________________

Pharmacy ______________________________ Phone: ______________________

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems or Defects
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valves or Joints
- ☐ Rods, Pins, Screws
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Diabetes
  - ☐ Controlled
  - ☐ Uncontrolled
- ☐ Arthritis, Rheumatism
- ☐ Lupus
- ☐ Nervous Problems
- ☐ Circulatory Problems
- ☐ Respiratory Disease
- ☐ Asthma
- ☐ Blood Disease
- ☐ Chemical Dependency
- ☐ Stroke
- ☐ Tobacco Habit
- ☐ Thyroid Problems
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Back Problems
- ☐ Epilepsy
- ☐ Cancer
- ☐ Tumor or Growth
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ General Allergies
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Recent Weight Loss
- ☐ Sinus Problems
- ☐ HIV / AIDS or Other Immunosuppressive Disorders
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Hemophilia

1. Are you in good health? ☐ Yes ☐ No
2. Have you had any major Surgeries, Illnesses or Operations? ☐ Yes ☐ No

   If yes, please explain ______________________________

3. Is your physician treating you for any ongoing medical conditions? ☐ Yes ☐ No

   If yes, please explain ______________________________

4. Have you ever responded adversely to medical or dental treatment? ______________________________
5. (Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No
6. Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No
7. Have you ever had to take antibiotics before dental appointments? ☐ Yes ☐ No
8. Is there anything else we should know about your medical history? ______________________________

Current Medications:		Allergies:
		☐ Penicillin
		☐ other antibiotics
		☐ Aspirin
		☐ Codeine
		☐ other narcotics
		☐ Local Anesthetic
		☐ Latex
		☐ Sulfa
		☐ Other ____________

The previous information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ ______________________________

Date *Signature*