James W. Spradley D.D.S.

MEDICAL HISTORY

Patient Name: _____ **Birth Date:** _____

Physician's Name _____ **Phone #:** _____ **Last Visit** _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ No

If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No *If yes, please explain:* _____

Do you use controlled substances? ☐ Yes ☐ No *If yes, please explain:* _____

Women: *are you...*

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

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine

☐ Acrylic ☐ Metal ☐ Local Anesthetics

☐ Latex ☐ Perfumes ☐ Other

If other, please explain: _____

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

Rheumatic Fever	Y N	Dry Mouth	Y N	Blood Transfusion	Y N	Cancer	Y N
Cardiovascular Disease	Y N	Jaundice	Y N	AIDS/HIV	Y N	Glaucoma	Y N
Irregular Heart Beat	Y N	Stomach Ulcers	Y N	Artificial Heart Valve	Y N	Chemotherapy	Y N
Mitral Valve Prolapse	Y N	Persistent Cough	Y N	High Blood Pressure	Y N	Herpes	Y N
Asthma/Trouble Breathing	Y N	Bruise Easily	Y N	Swollen Ankles	Y N	Drugs Addiction	Y N
Emphysema	Y N	Radiation TX	Y N	Excessive Thirst	Y N	Stroke	Y N
Hives or Rash	Y N	Heart Abnormalities	Y N	Hepatitis A	Y N	Thyroid or Parathyroid	Y N
Fainting Spells	Y N	Angina (Chest Pain)	Y N	Hepatitis B, C	Y N	Recent Weight Loss	Y N
Hemophilia	Y N	Pace Maker	Y N	Tuberculosis	Y N	Leukemia	Y N
Sickle Cell Disease	Y N	Diabetes	Y N	Abnormal Bleeding	Y N	Psychiatric Care	Y N
Scarlet Fever	Y N	Liver Disease	Y N	Anemia	Y N	Taken Phen Fen or Redux	Y N
Heart Attack	Y N	Arthritis	Y N	Anaphylaxis	Y N	Taken Viagra/Cialis/Levitra	Y N
Heart Murmur	Y N	Kidney Problems	Y N	Artificial Joint	Y N	Shortness of Breath Lying Down	Y N
Seizure (Epilepsy)	Y N	Venereal Disease	Y N	Headaches	Y N	Shortness of Breath w/mild Excercise	Y N

Blood Pressure _____ **Pulse** _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to notify the dental office of any changes of my/patient's medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ **DATE** _____