Brian Williams, D.D.S., F.A.G.D., LTD.
PREVENTIVE & RECONSTRUCTIVE DENTISTRY

Medical Information

Patients Name_____
Last First Middle Nickname

Correct answers to the following questions will allow your dentist to treat you so there WILL NOT be an emergency. However, if an emergency situation does arise, this information will help insure proper treatment. As before, your answers are for our records only and will be considered confidential.

Have you been under the care of a medical doctor during the past two years? [ ] Yes [ ] No
If Yes, what for? _____
Physician's Name _____
Address _____ City _____ State _____ Zip _____

Have you taken any medication or drugs during the past two years? [ ] Yes [ ] No

Are you taking any medication, drugs or pills now? [ ] Yes [ ] No
If Yes, please list name and dosage _____

Are you aware of having an allergic (**or adverse reaction**) to any medication or substance? [ ] Yes [ ] No
If Yes, please list _____

Have you been a patient in a hospital during the past five years? [ ] Yes [ ] No
Do you smoke or chew tobacco? [ ] Yes [ ] No

Indicate which of the following you have had or have presently:

Heart (surgery, disease, attack)	[ ] Yes [ ] No	Ulcers	[ ] Yes [ ] No	Hepatitis	[ ] Yes [ ] No
Chest Pain	[ ] Yes [ ] No	Diabetes	[ ] Yes [ ] No	Venereal Disease	[ ] Yes [ ] No
Congenital Heart Disease	[ ] Yes [ ] No	Thyroid Problems	[ ] Yes [ ] No	A.I.D.S.	[ ] Yes [ ] No
Heart Murmur	[ ] Yes [ ] No	Glaucoma	[ ] Yes [ ] No	H.I.V. Positive	[ ] Yes [ ] No
High Blood Pressure	[ ] Yes [ ] No	Contact Lenses	[ ] Yes [ ] No	Cold Sores/Fever Blisters	[ ] Yes [ ] No
Mitral Valve Prolapse	[ ] Yes [ ] No	Emphysema	[ ] Yes [ ] No	Blood Transfusion	[ ] Yes [ ] No
Artificial Heart Valve	[ ] Yes [ ] No	Chronic Cough	[ ] Yes [ ] No	Hemophilia	[ ] Yes [ ] No
Heart Pacemaker	[ ] Yes [ ] No	Tuberculosis	[ ] Yes [ ] No	Sickle Cell Disease	[ ] Yes [ ] No
Rheumatic Fever	[ ] Yes [ ] No	Asthma	[ ] Yes [ ] No	Bruise Easily	[ ] Yes [ ] No
Arthritis/Rheumatism	[ ] Yes [ ] No	Hay Fever	[ ] Yes [ ] No	Liver Disease	[ ] Yes [ ] No
Cortisone Medicine	[ ] Yes [ ] No	Latex Sensitivity	[ ] Yes [ ] No	Yellow Jaundice	[ ] Yes [ ] No
Swollen Ankles	[ ] Yes [ ] No	Allergies or Hives	[ ] Yes [ ] No	Neurological Disorders	[ ] Yes [ ] No
Stroke	[ ] Yes [ ] No	Sinus Trouble	[ ] Yes [ ] No	Epilepsy or Seizures	[ ] Yes [ ] No
Drug Addiction	[ ] Yes [ ] No	Radiation Therapy	[ ] Yes [ ] No	Fainting or Dizzy Spells	[ ] Yes [ ] No
Artificial Joints	[ ] Yes [ ] No	Chemotherapy	[ ] Yes [ ] No	Nervous/Anxious	[ ] Yes [ ] No
Kidney Trouble	[ ] Yes [ ] No	Tumors	[ ] Yes [ ] No	Psychiatric/Psychological Care	[ ] Yes [ ] No

Do You use more than two pillows to sleep? [ ] Yes [ ] No

Have you lost or gained more than 10 pounds in the past year? [ ] Yes [ ] No

Do you have or have you had any disease, condition, or problem not listed? [ ] Yes [ ] No
If Yes, please list: _____

Women Are you: **Pregnant?** [ ] Yes, _____ months [ ] No **Nursing?** [ ] Yes [ ] No **Taking birth control?** [ ] Yes [ ] No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who release such information to you. I will notify my doctor of any change in my health or medication.

_____ _____
Patient/Guardian Signature **Date**