WINTER PARK LIFE SMILES

PATIENT MEDICAL HISTORY

Patient Name _____ DOB _____M _____D _____Y

Address _____ Cell Phone _____

Sex ☐M ☐F Height _____ Weight _____ lbs. Physician's Name & Phone _____

Medical Conditions: Please check Yes or No

Abnormal Bleeding	☐Y ☐N	Heart Surgery	☐Y ☐N	**ALLERGIES**	
Alcohol Abuse	☐Y ☐N	Hemophilia	☐Y ☐N	Aspirin	☐Y ☐N
Anemia	☐Y ☐N	Hepatitis A, B or C	☐Y ☐N	Codeine	☐Y ☐N
Angina Pectoris	☐Y ☐N	HIV+ or AIDS	☐Y ☐N	Dental Anesthetics	☐Y ☐N
Arthritis	☐Y ☐N	High Blood Pressure	☐Y ☐N	Penicillin	☐Y ☐N
Artificial Joints	☐Y ☐N	Kidney Problems	☐Y ☐N	Sulfa Drugs	☐Y ☐N
Artificial Heart Valve	☐Y ☐N	Liver Disease	☐Y ☐N	Tetracycline	☐Y ☐N
Asthma	☐Y ☐N	Low Blood Pressure	☐Y ☐N	Erythromycin	☐Y ☐N
Blood Transfusion	☐Y ☐N	Mitral Valve Prolapse	☐Y ☐N	Metal Reactions	☐Y ☐N
Breathing Problems	☐Y ☐N	Pace Maker	☐Y ☐N	Latex	☐Y ☐N
Cancer	☐Y ☐N	Pain in Jaw Joints	☐Y ☐N	Nitrous Oxide	☐Y ☐N
Colitis or IBS	☐Y ☐N	Psychiatric Conditions	☐Y ☐N	Any Foods	☐Y ☐N
Congenital Heart Defect	☐Y ☐N	Radiation Therapy	☐Y ☐N	**Any other allergies not listed:**	
Cosmetic Surgery	☐Y ☐N	Rheumatic Fever	☐Y ☐N		
Diabetes	☐Y ☐N	Seizures	☐Y ☐N		
Drug Abuse	☐Y ☐N	Sleep Apnea	☐Y ☐N		
Emphysema/ COPD	☐Y ☐N	Sinus Problems	☐Y ☐N		
Epilepsy	☐Y ☐N	Stroke	☐Y ☐N		
Fainting Spells	☐Y ☐N	Thyroid Problems	☐Y ☐N		
Fever Blisters	☐Y ☐N	Tuberculosis	☐Y ☐N	**FOR WOMEN ONLY**	
Glaucoma	☐Y ☐N	Ulcers	☐Y ☐N	Are you pregnant?	☐Y ☐N
Hay Fever	☐Y ☐N	Venereal Disease or STD	☐Y ☐N	Are you taking birth control?	☐Y ☐N
Heart Attack	☐Y ☐N	Yellow Jaundice	☐Y ☐N	Are you nursing?	☐Y ☐N
Headaches	☐Y ☐N	**Any other conditions:**			

Please list any medications you are taking at this time: _____

1. Do you feel nervous about dental treatment? ☐Y ☐N
2. Have you ever had a bad experience in a dental office? ☐Y ☐N
3. Have you been in the hospital in the last two years? ☐Y ☐N
4. If you answered "Yes" to cancer please explain _____
5. Are you having pain or discomfort at this time? ☐Y ☐N
6. Have you been under the care of a doctor recently? ☐Y ☐N
7. Are you a smoker? ☐Y ☐N

The above information is true and I do hereby and request for myself or the above patient, dental services and/or whatever procedures the doctor may deem necessary.

_____
Patient or Guardian Signature:

_____
Date

OFFICE USE ONLY: Medical alerts summary