Prosthodontics
OF NEW YORK

MEDICAL HISTORY

PATIENT NAME _____
LAST FIRST MIDDLE

PHYSICIANS NAME _____

ADDRESS/PHONE # _____ _____

_____ _____

DATE OF LAST VISIT _____

LIST CURRENT MEDICATIONS: _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? PLEASE CIRCLE
ASPIRIN PENICILLIN CODEINE LATEX RUBBER ACRYLIC
OTHER: _____

DO YOU NEED PREMEDICATION PRIOR TO A DENTAL VISIT? YES NO
IF YES, WHY? _____

HAVE YOU EVER BEEN HOSPITALIZED? YES NO
IF YES, WHY? _____

HAVE YOU EVER HAD A SERIOUS ILLNESS OR MAJOR INJURY? YES NO
IF YES, WHY? _____

DO YOU SMOKE? YES NO HOW MUCH? _____

DO YOU WEAR CONTACT LENSES? YES NO

(*WOMEN*) PLEASE CHECK IF APPROPRIATE: TAKING BIRTH CONTROL PILLS
PREGNANT/TRYING TO GET PREGNANT NURSING

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

RHEUMATIC FEVER	ASTHMA	ARTIFICIAL JOINT
RHEUMATIC HEART DISEASE	DIABETES	SKIN RASH / HIVES
HEART MURMUR	FREQUENT URINATION	CORTISONE TREATMENT
MITRAL VALVE PROLAPSE	EXCESSIVE THIRST	HIV
PROSTHETIC HEART VALVE	HYPOGLYCEMIA	AIDS
IRREGULAR HEART BEAT	ANEMIA	GLAUCOMA
SHORTNESS OF BREATH	BRUISING	THYROID PROBLEMS
CHRONIC TIREDNESS	CANCER	BLOOD TRANSFUSION
CHEST PAIN / ANGINA	RADIATION THERAPY	CHEMICAL DEPENDENCY
HEART ATTACK	CHEMOTHERAPY	PSYCHIATRIC CARE
HIGH BLOOD PRESSURE	TUMOR OR GROWTH	COLD SORES
HIGH CHOLESTEROL	STOMACH ULCERS	SICKLE CELL DISEASE
STROKE	KIDNEY PROBLEMS	ARTHRITIS
SEIZURES / CONVULSIONS	RENAL DIALYSIS	ALLERGIES (MEDICINES)
FAINTING / DIZZINESS	TUBERCULOSIS	PARKINSONS DISEASE
HEADACHES	PERSISTENT COUGH	DRUG ADDICTION

OTHER MEDICAL ISSUES NOT CIRCLED ABOVE: _____

_____

SIGNATURE: _____ DATE: _____

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