The Smile Zone

Name_____ Date_____
Address_____
Date of Birth _____ Gender_____ Family Status_____
Social Security #_____ Phone #_____ Work #_____
In Case of Emergency Notify _____ Phone # _____
Preferred appointment times: ___ Morning ___ Afternoon ___ Evening ___ Any Time __M__T__W__T__F

If you are completing this form for another person, what is your relationship to that person_____.
In the following questions, please check which ever applies. Your answers are for our records only and will be considered confidential.

Medical History

Yes **No**

___ ___ 1. The name, telephone number and address of your **Medical Doctor:**_____
_____
Your last physical exam was on_____

___ ___ **2.** Have you had a serious illness or operation _____

3. Are you taking any of the following medications

___ ___ a. Antibiotics or sulfa drugs _____
___ ___ b. Anticoagulants (blood thinners)_____
___ ___ c. Medicine for high blood pressure _____
___ ___ d. Cortisone (steroids) _____
___ ___ e. Tranquilizers _____
___ ___ f. Antihistamines _____
___ ___ g. Aspirin _____
___ ___ h. Insulin or any other medicine for diabetes _____
___ ___ i. Medicine for heart trouble _____
___ ___ j. Nitrogylcerin _____
___ ___ k. Oral contraceptive or other hormonal therapy _____
___ ___ l. Fluoride Supplement (children 14 and under) _____
___ ___ m. Vitamins, Over the Counter or Herbal Medications _____
___ ___ n. Other, Please describe _____
_____

___ ___ 4. Are you **allergic** or have you had a bad reaction to any medications, food, latex or other _____
_____

5. Do you have or have you had any of the following diseases or problems:

		a. **HEART**	**Yes**	**No**	
___	___	Mitral Valve prolapse	___	___	g. Arthritis
___	___	Damaged or artificial heart valves	___	___	h. Kidney trouble
___	___	Rheumatic heart disease	___	___	i. Asthma
___	___	Heart murmur	___	___	j. Persistent cough, cough up blood
___	___	Congenital heart lesion	___	___	k. Tuberculosis
			___	___	l. Fainting spells or seizures
___	___	b. Joint replacement	___	___	m. Epilepsy
___	___	c. Diabetes	___	___	n. Psychiatric problems