

# MEDICAL HISTORY

**GLENN N. PHILLIPS, DMD**

**ANDREW W. PHILLIPS, DMD**

**Patient Name** \_\_\_\_\_ **Birth date** \_\_\_\_\_ **Age** \_\_\_\_\_

Are you currently being treated by a physician? \_\_\_\_\_ Y N  
 Have you had a major operation or been hospitalized? \_\_\_\_\_ Y N  
 Do you have a heart condition? \_\_\_\_\_ Y N  
 Have you had a serious injury to your head, neck or face? \_\_\_\_\_ Y N  
 Do you need to take antibiotic -medication before dental visits? \_\_\_\_\_ Y N  
 Do you smoke or use tobacco? \_\_\_\_\_ Y N  
 When was your last physical exam? \_\_\_\_\_ Blood pressure \_\_\_\_\_ / \_\_\_\_\_

Are you **ALLERGIC** or have you experienced any reaction to the following?.....

Local anesthetics (novocaine) __	Y	N	Codeine _____	Y	N
Penicillin or other antibiotics __	Y	N	Sulfa drugs _____	Y	N
Aspirin _____	Y	N	Non Steroidal _____	Y	N
Latex _____	Y	N	Other drugs _____	Y	N

Are you taking any of the following medications

Antibiotics _____	Y	N	Tranquilizers _____	Y	N
Blood Thinners _____	Y	N	Insulin or diabetic __	Y	N
Blood pressure medication _____	Y	N	Heart medication __	Y	N
Thyroid medication _____	Y	N	Aspirin _____	Y	N
Cortisone/steroids _____	Y	N	Recreational Drugs _	Y	N

Please list all current medications: (including non prescription)

\_\_\_\_\_

\_\_\_\_\_

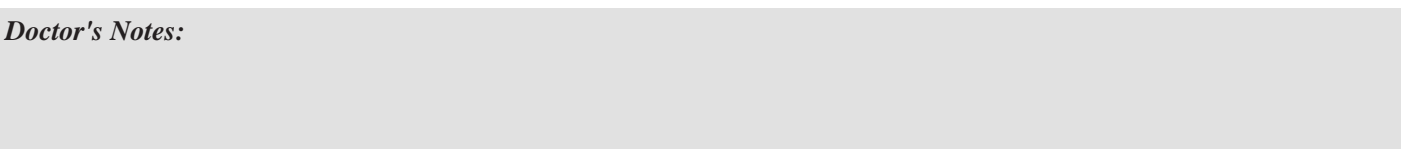
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*Have you ever had or do you now have any conditions listed:*

Abnormal bleeding	Y	N	Epilepsy	Y	N	Liver disease	Y	N
Alcohol/Drug abuse	Y	N	Excessive urination	Y	N	Leukemia	Y	N
Anemia	Y	N	Excessive thirst	Y	N	Low blood pressure	Y	N
Annina/Chest pain	Y	N	Fainting spells, dizziness	Y	N	Mitral valve prolapse	Y	N
Arteriosclerosis	Y	N	Frequent headaches	Y	N	Pacemaker	Y	N
Arthritis	Y	N	Glaucoma/Eye problems	Y	N	Psychiatric problems	Y	N
Artificial bones/Joints	Y	N	Heart attack	Y	N	Prosthetic heart valve	Y	N
Asthma/Allergies	Y	N	Heart murmur	Y	N	Radiation treatment	Y	N
Blood transfusion	Y	N	Heart surgery	Y	N	Rheumatic / Scarlet fever	Y	N
Cancer/Chemotherapy	Y	N	Hemophilia	Y	N	Seizures	Y	N
Chest pain upon exertion	Y	N	Hearing loss	Y	N	Sexual transmitted disease	Y	N
Congenital heart defect	Y	N	Hepatitis	Y	N	Shingles	Y	N
Diabetes	Y	N	Herpes/Fever blisters	Y	N	Sickle cell disease	Y	N
Difficulty swallowing	Y	N	High blood pressure	Y	N	Sinus problems	Y	N
Earache	Y	N	HIV / AIDS	Y	N	Stroke	Y	N
Easy bruising	Y	N	Hospitalized for any reason	Y	N	Thyroid problems	Y	N
Emphysema	Y	N	Kidney problems	Y	N	Tuberculosis (TB)	Y	N
						Ulcers	Y	N

Do you have any condition not mentioned above that we should know about? \_\_\_\_\_

**Doctor's Notes:**



Patient Signature \_\_\_\_\_ Today's Date \_\_\_\_\_