Alyce O'Brien, D.D.S. & Jack Batjer, D.D.S.

Patient Name: _____ Birthdate: _____

Medical History

Please circle:

Physician's Name _____ Phone # _____

Last Appointment: Date _____ For what reason? _____

YES NO 1) Are you currently under the care of a physician?

YES NO 2) Have there been any changes in your general health in the last year?

YES NO 3) Have you been hospitalized during the past five years? _____

YES NO 4) Have you been under the care of a physician during the past two years? _____

YES NO 5) Are you taking any medication, drugs or pills including non-prescription drugs?

If yes, what kind and dose? _____

YES NO 6) Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?

Penicillin/Amoxicillin Aspirin Codeine Dental Anesthetic Latex/Rubberdam

Erythromycin Sulfa Tetracycline Metals _____ Other _____

YES NO 7) Do you have or have you had a problem with alcohol or drugs?

YES NO 8) Have you ever taken Fen-phen (Redux or Pondamin)?

YES NO 9) Have you had or do you presently have any of the following? If so, please circle:

Heart murmur/defect	Pacemaker	Hemophilia	Ulcers	Chronic cough
Mitral valve prolapse	Neurological condition	Diabetes (or family history)	Hepatitis B	Epilepsy/Seizures
Rheumatic Fever	Drug addiction	Radiation/Chemotherapy	Sickle Cell Anemia	Thyroid Problems
Artificial Joint/Valve	Stroke	Anemia or blood disorder	Fainting/Dizziness	Kidney Disease
Glaucoma	Indwelling catheter	Frequent headaches	Asthma	Allergies or Hives
Arteriosclerosis	Steroids/Cortisone	Lumps/Swollen glands	Hepatitis C	Psychiatric treatment
Heart ailment	Hepatitis A	High blood pressure	Blood transfusion	Herpes or cold sores
Chest pain/angina	Cancer or tumor	Low blood pressure	Bruise easily	Emphysema
Arthritis	Sinus problems	Abnormal bleeding	HIV+ or AIDS	Venereal disease
Alcoholism	Liver disease	Tuberculosis/lung problems	Bulimia/anorexia	Implants

YES NO 10) Do you have any disease, condition, or problem not listed above?
If yes, please explain:

_____

FOR WOMEN:

YES NO 1) Are you taking birth control? If yes, what type? _____

YES NO 2) Are you pregnant? If yes, week # _____

YES NO 3) Are you nursing?

Patient Signature (Parent or Guardian) _____ Date _____

Staff Signature _____ Date _____