Welborne and White
EXCELLENCE IN DENTISTRY

Medical History

Medical Alert ______________________________

1. Physician's Name ______________________________ Phone ______________

   Address ______________________ City ______________ State __________ Zip ________

2. Current Medications ______________________________

3. Any Allergy to drugs or any Anesthesia? ______________________________

4. Indicate which of the following you have had, or have at present. Check "yes" or "no" to each item.

Heart (surgery, disease, attack)... ☐ Yes ☐ No
Chest Pain.... ☐ Yes ☐ No
Congenital Heart Disease.... ☐ Yes ☐ No
Heart Murmur.... ☐ Yes ☐ No
High Blood Pressure.... ☐ Yes ☐ No
Mitral Valve Prolapse.... ☐ Yes ☐ No
Artificial Heart Valve.... ☐ Yes ☐ No
Heart Pacemaker.... ☐ Yes ☐ No
Rheumatic Fever.... ☐ Yes ☐ No
Arthritis/ Rheumatism.... ☐ Yes ☐ No
Cortisone Medicine.... ☐ Yes ☐ No
Swollen Ankles.... ☐ Yes ☐ No
Stroke.... ☐ Yes ☐ No
Diet (special/ restricted).... ☐ Yes ☐ No
Artificial Joints (hip, knee, etc.).... ☐ Yes ☐ No
Kidney Trouble.... ☐ Yes ☐ No
Ulcers.... ☐ Yes ☐ No
Diabetes.... ☐ Yes ☐ No
Thyroid Problems.... ☐ Yes ☐ No
Glaucoma.... ☐ Yes ☐ No
Emphysema.... ☐ Yes ☐ No
Chronic Cough.... ☐ Yes ☐ No
Tuberculosis.... ☐ Yes ☐ No
Asthma.... ☐ Yes ☐ No
Hay Fever.... ☐ Yes ☐ No
Latex Sensitivity.... ☐ Yes ☐ No
Allergies or Hives.... ☐ Yes ☐ No
Sinus Trouble.... ☐ Yes ☐ No
Radiation Therapy.... ☐ Yes ☐ No
Chemotheraphy.... ☐ Yes ☐ No
Tumors.... ☐ Yes ☐ No
Hepatitus A(infectious) B(serum). ☐ Yes ☐ No
Venereal Disease.... ☐ Yes ☐ No
A.I.D.S. .... ☐ Yes ☐ No
H.I.V. Positive.... ☐ Yes ☐ No
Cold Sores/ Fever Blisters.... ☐ Yes ☐ No
Blood Transfusion.... ☐ Yes ☐ No
Hemophilia.... ☐ Yes ☐ No
Sickle Cell Disease.... ☐ Yes ☐ No
Bruise Easily.... ☐ Yes ☐ No
Liver Disease.... ☐ Yes ☐ No
Yellow Jaundice.... ☐ Yes ☐ No
Neurological Disorders.... ☐ Yes ☐ No
Epilepsy or Seizures.... ☐ Yes ☐ No
Fainting or Dizzy Spells.... ☐ Yes ☐ No
Nervous/ Anxious.... ☐ Yes ☐ No
Psychiatric/ Psychological Care.. ☐ Yes ☐ No

5. List any other diseases or conditions not listed above.

____

6. Are you: Pregnant? ☐ Nursing? ☐ Taking birth control pills? ☐

7. Have you ever taken Phen Phen? Yes ☐ No ☐

I understand the above information to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowedge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/ Guardian Signature ______________________________ Date ______________

HISTORY REVIEW

DOCTOR SIGNATURE______________________________ DATE ______________