

MEDICAL HISTORY FORM

Charles B. Felts, III D.D.S., M.S.D.

Diplomate of American Board of Periodontology

Elizabeth Felts Randall, DMD, MS

Diplomate of American Board of Periodontology

Name: _____

Height: _____ Weight: _____ Age: _____

How is your current physical health? Good Fair Poor

Physician's Name, Address, and Phone Number: _____

When were you last seen by a doctor? _____ Why? _____

Please give the name and dosage of all current medications: _____

Please indicate if you are allergic to any of the following medications by checking the corresponding box:

- | | |
|--|---|
| <input type="checkbox"/> Penicillin, Amoxicillin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Tetracycline, Doxycycline, Vibramycin | <input type="checkbox"/> Narcotics, Demerol |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Ibuprofen, Motrin | <input type="checkbox"/> Other: _____ |

Please indicate any of the following conditions by checking off the corresponding box:

- | | |
|---|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Condition or Murmur | <input type="checkbox"/> Asthma/Emphysema/Bronchitis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Sinus Problems/Allergies |
| <input type="checkbox"/> Artificial Heart Valve/Pacemaker | <input type="checkbox"/> Radiation Therapy/Chemotherapy |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tumors, Cancer, Malignancies |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis A, B, C |
| <input type="checkbox"/> Artificial Joints (Hips, Knee, Etc.) | <input type="checkbox"/> AIDS/HIV Positive |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Venereal Disease/STD |
| <input type="checkbox"/> Ulcers/Stomach Problems | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Family Member with Diabetes | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Excessive or Abnormal Bleeding | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Anemia/Sickle Cell Anemia | <input type="checkbox"/> Psychiatric/Psychological Care |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Alcohol/Drug Use |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Immune System Disorders | Women: <input type="checkbox"/> Pregnant or Nursing |
| <input type="checkbox"/> Tobacco Use | |

Please list previous surgeries and hospitalizations in the last 5 years _____

Indicate which of the following you have had or have at the present.

Circle yes or no

- Have you had any serious trouble associated with any previous dental treatment? Yes No
If yes, explain: _____
- Are you required to restrict your activity or diet? Yes No
If yes, why? _____
- Do you have any disease, condition, or problem not listed above that you think I should know about?..... Yes No
If yes, please list: _____

Emergency Contact: _____

Phone: _____ Relationship to patient: _____

Signature

Date