NOELLE DAVIS, DDS
FAMILY DENTISTRY

Medical History

PATIENT NAME: _____ **DOB:** _____

Email_____ **cell #**_____

Medical History

Medical Doctor's Name: _____ Phone: _____ Last Exam: _____

Are you under a Doctor's care now? YES NO If so, for what reason? _____

(Women) Are you pregnant? YES NO How far along? _____

Are you taking any medications, including non-prescriptions? YES If yes, please list:

1. _____ 4._____ 7._____ 10. _____
2. _____ 5._____ 8._____ 11. _____
3. _____ 6._____ 9._____ 12. _____

Have you ever had any of the following? Please circle even if "No"

Heart (Surgery, Disease, Attack)	Yes No	Asthma	Yes No	HIV Positive	Yes No
Heart Murmur	Yes No	Diabetes I or II	Yes No	Tuberculosis	Yes No
Mitral Valve Prolapse	Yes No	Epilepsy	Yes No	Liver Disease	Yes No
Artificial Heart Valve	Yes No	Jaundice	Yes No	Treatment for Depression	Yes No
Heart Pacemaker	Yes No	Hepatitis	Yes No	Psychiatric Treatment	Yes No
Rheumatic Fever	Yes No	Circle one: Type A B C		Prolonged Bleeding	Yes No
High Blood Pressure	Yes No	Glaucoma	Yes No	Cancer	Yes No
Stroke	Yes No	Kidney Issues	Yes No	Type:_____	
Arthritis	Yes No	Herpes	Yes No	Chemotherapy	Yes No
Artificial Joints (hip, knee, etc.)	Yes No	AIDS	Yes No	Radiation Therapy	Yes No
Latex Sensitivity	Yes No				

Are there any other medical conditions you have had that are not listed? Yes No If yes, please explain:

_____

Drug Allergies: YES NO Please list: 1._____ 2._____ 3._____

Have you been hospitalized in the last two years? Yes No If yes, please explain:

_____

Have you ever been told you need to routinely take antibiotics prior to dental treatment? Yes No

Do you use tobacco products? Yes No

Do you have a history of drug or alcohol abuse? Yes No If yes, please explain:_____

I have read my Medical History and confirm that it adequately states past and present conditions.

Date: _____ Signature: _____ updated_____