ALICIA L. DWYER D.D.S., P.A.

Patient's Name_____ **Height: ____ Weight: _____**

Last First Date of Birth

1	Physician's name, Address			Comments:
2	Are you under a physician's care? Since when? Why?	YES	NO	
3	When was your last complete physical exam?			
4	Are you taking any medication or substances?	YES	NO	
5	Do you routinely take health related substances?	YES	NO	
6	Are you allergic to any medications or substances? (if yes , please list on the back of this form)	YES	NO	
7	Do you have any other allergies?	YES	NO	
8	Do you have any problems with penicillin, antibiotics, anesthetics or any other medications?	YES	NO	
9	Are you sensitive to any metals or latex?	YES	NO	
10	Are you pregnant or suspect you might be?	YES	NO	
11	Do you use any birth control medication?	YES	NO	
12	Have you ever been treated for or have been told you may have heart disease?	YES	NO	
13	Do you have a pacemaker or an artificial heart valve implant?	YES	NO	
14	Have you ever had rheumatic fever?	YES	NO	
15	Are you aware of any heart murmurs?	YES	NO	
16	Do you have high or low blood pressure?	YES	NO	
17	Have you ever had a serious illness or major surgery? (If yes, please explain.)	YES	NO	
18	Have you ever had radiation treatment, chemo treatment for tumor growth or other condition?	YES	NO	
19	Do you have inflammatory disease, such as arthritis or rheumatism?	YES	NO	
20	Do you have any artificial joints/prosthesis?	YES	NO	
21	Do you have any blood disorders, such as anemia, leukemia, etc.?	YES	NO	
22	Have you ever bleed excessively after being cut or injured?	YES	NO	
23	Do you have any stomach problems?	YES	NO	
24	Do you have any kidney problems?	YES	NO	
25	Do you have any liver problems?	YES	NO	
26	Are you diabetic?	YES	NO	
27	Do you have asthma?	YES	NO	
28	Do you have epilepsy or seizure disorders?	YES	NO	
29	Do you or have you had venereal disease?	YES	NO	
30	Have you tested HIV positive?	YES	NO	
31	Do you have AIDS?	YES	NO	
32	Have you had or do you test positive for hepatitis?	YES	NO	
33	Do you or have you had T.B.?	YES	NO	
34	Do you smoke, chew, use snuff or any other forms of tobacco?	YES	NO	
35	Do you consume alcoholic beverages?	YES	NO	
36	Do you habitually use controlled substances?	YES	NO	
37	Have you had psychiatric treatment?	YES	NO	
38	Do you have any disease, condition or problem not listed? (explain)	YES	NO	
39	Is there anything else we should know about your health that we have not covered in this form?	YES	NO	
40	Would you like to speak to the doctor privately about any problem?	YES	NO	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S Signature_____ Date_____

DENTIST'S Signature_____ Date_____

MEDICAL HISTORY