DONOHUE & DONOHUE D.D.S., PC

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PATIENT MEDICAL HISTORY

Name:_____ Soc. Sec. #: _____
(First) (MI) (Last)

CHANGE IN ADDRESS_____**EMAIL**_____**CELL PHONE**_____

Preferred Name/Nickname (if any): _____ Date of Birth : _____M_____F_____

Medical History:

Do you have, or have had, any of the following? Please check if YES:

__Abnormal Bleeding	**__Chest Pains**	**__Hepatitis A B C (circle one)**
__Alcoholism	**__Cold/Canker Sores**	**__Learning Disability**
__Alzheimers or Dementia	**__Colitis**	**__Liver Disease**
__Anemia	**__COPD**	**__Pacemaker**
__Artificial Heart Valve	**__Diabetes**	**__Psychiatric Care**
__Artificial Joints	**__Depression/Anxiety**	**__Radiation Therapy or Treatment**
__Arthritis	**__Epilepsy or Seizures**	**__Smoker or Tobacco User**
__Asthma	**__Fainting or Dizziness**	**__Stroke**
__Autism	**__Glaucoma**	**__Thyroid Disease**
__Bariatric Surgery	**__Headaches**	**__Tuberculosis**
__Blood Disorder or Hemophilia	**__Hearing Disorder**	**__Ulcers**
__Blood Transfusion	**__HIV/Aids**	**__Heart Surgery**
__Cancer	**__Kidney Problems**	**__Heart Disease or Heart Attack**
__Chemotherapy	**__High Blood Pressure**	**__Heart Stents**

If you answered YES to any of the above please explain_____

Is there any other disease/condition or problem that is not listed above, including prior surgeries
_____
_____
_____

Do you consider yourself to be in good health? **YES NO**
Who is your family doctor? _____
Have you been hospitalized or had a serious illness/injury within the past year? **YES NO**
If yes please explain: _____
Women Only: Are you Pregnant or trying to get pregnant **YES NO** Nursing? **YES NO**
If yes, how many weeks _____

Please list any Medications you are currently taking (Include Over the Counter, Vitamins and natural remedies)

_____

_____

_____

_____

Do you take or have you ever taken Bisphosphonates (Osteoporosis Medications such as Reclast, Fosomax)? YES NO

Are you **ALLERGIC** to any of the following? **YES NO** (Please Circle)

Penicillin	Red Dye	Codeine	Latex
Erythromycin	Sulfa	Tetracycline	Jewelry
Dental Anesthetics			

Other:_____
*If yes to any of the above please explain reaction that occurs.*_____

Dental History
When was the last time you visited a dental office?_____

Patient/Guardian Signature_____Today's Date_____