Blue Ash Smiles

Adult Medical History

Patient Name_____ Date of Birth_____

Preferred Phone #_____ Insurance change? Y N

Physician Name_____

1.	Are you having any discomfort at this time?	Yes	No
2.	Have you seen a physician in the last 2 years?	Yes	No
3.	Are you NOW taking any prescriptions, drugs, medicines or pills? Please List _____	Yes	No
4.	Have you ever had excessive bleeding that required special treatment?	Yes	No
5.	Do you have ANY ALLERGIES to drugs or medicines? Please List_____	Yes	No
6.	Have you ever had an unusual reaction to dental anesthetic? (Novocain, Xyloclane)	Yes	No
7.	Have you ever been told you have cancer or a tumor?	Yes	No
8.	Have you ever been treated for osteoporosis?	Yes	No
9.	Have you ever or are you currently using tobacco products or E-cigarettes?	Yes	No

10. Please circle any of the following that you have had or have at present:

Heart Failure	Ulcers	Arthritis	Hemophilia
Heart Attack	Rheumatic Fever	Cortisone Medication	Cold Sores
High Blood Pressure	Glaucoma	Chronic Cough	Enlarged Glands
Heart Murmur	Tuberculosis	AIDS/HIV	Epilepsy/Seizures
Stroke	Asthma	Anemia	ADD/ADHD
Artificial Joints	Blood Transfusion	Fainting/Dizzy Spells	Anxiety
Congenital Heart Lesions	Sinus Trouble	Pain in Jaw Joint	Sickle Cell
Allergies/Hives	Hepatitis A, B, or C	Kidney Disease	High Cholesterol
Heart Pacemaker	Diabetes I or II	Psychiatric Treatment	Radiation Therapy
Artificial Heart Valve	Thyroid Disease	Liver Disease	Chemotherapy
Mitral Valve Prolapse	Other- Please List _____		

11.	WOMEN: Are you Pregnant now?_____Months	Yes	No
	Do you anticipate becoming pregnant soon?	Yes	No
	Are you taking Birth Control Pills?	Yes	No
	Are you nursing?	Yes	No

TO THE BEST OF MY KNOWLEDGE, ALL OF THE ABOVE INFORMATION IS CORRECT AND TRUE. IF THERE SHOULD BE A CHANGE IN MY HEALTH OR MEDICATIONS I WILL NOTIFY THE DOCTOR AS SOON AS POSSIBLE.

Date_____ Patient Signature_____ Doctor Signature_____