Saini Smiles — Medical History Form

Patient Name _____ DOB_____ Today's Date_____

Yes	No	Rheumatic Fever	Yes	No	Asthma
Yes	No	Mitral Valve Prolapse	Yes	No	Respiratory Problem
Yes	No	Heart Murmur	Yes	No	Emphysema
Yes	No	Joint Replace: Date:_____	Yes	No	Diabetes
Yes	No	Heart Attack: Date:_____	Yes	No	Convulsions
Yes	No	Fainting	Yes	No	Seizures
Yes	No	Stroke: Date:_____	Yes	No	Epilepsy
Yes	No	Stents: Date:_____	Yes	No	Glaucoma
Yes	No	Arthritis	Yes	No	Anemia
Yes	No	Cardiac Pacemaker	Yes	No	Leukemia
Yes	No	Osteoporosis	Yes	No	Thyroid
Yes	No	High Cholesterol	Yes	No	Cancer
Yes	No	High Blood Pressure	Yes	No	Chemotherapy
Yes	No	Heart Disease	Yes	No	Radiation Therapy
Yes	No	Angina	Yes	No	Alzheimer's
Yes	No	Hepatitis A, B, or C	Yes	No	Dementia
Yes	No	Liver Disease	Yes	No	Sexual Transmitted Diseases
Yes	No	HIV	Yes	No	Tuberculosis
Yes	No	Are you taking Aspirin?	Yes	No	Do You Smoke?
Yes	No	Are you pregnant? Are you nursing?			How Much_____
Yes	No	Are you taking vitamins or herbal supplements?	Yes	No	Do You Drink Alcohol?
Yes	No	Are you or have you taken Fosamax or Aredia?			How Much_____
Yes	No	Are you taking a blood thinner, such as Coumadin?			
Yes	No	Does your Doctor require you to take antibiotics before dental appointments?			
Yes	No	Are you under any medical treatment now?_____			
Yes	No	Are you under any other treatment not listed above?_____			

Current Physician_____ Phone_____

List All Medications You Are Currently Taking_____

_____

_____

_____

_____

Are You Allergic To Any of The Following

Yes	No	Local Anesthetics	Yes	No	Penicillin
Yes	No	Other Antibiotic	Yes	No	Aspirin
Yes	No	Codeine	Yes	No	Latex / Rubber

Other? _____

Patient Signature_____ **Date**_____

Medical Changes: Yes No Sign_____ Date_____

Medical Changes: Yes No Sign_____ Date_____

Medical Changes: Yes No Sign_____ Date_____

Medical Changes: Yes No Sign_____ Date_____