Kenneth L. Andow

D D S • P C

Cosmetic and family dentistry with a caring touch

Medical History

Name: _____ Date: _____

Medical Doctor's Name: _____ Phone: _____

Date of last examination: _____

Have you been under the care of a medical doctor during the past two months? YES○ NO○

If yes, why? _____

Have you ever been hospitalized for any serious illness or operation? YES○ NO○

If yes, please list: _____

Are you currently taking any medications, drugs or pills on a regular basis? YES○ NO○

If yes, please list: _____

Are you allergic to or have you ever reacted adversely to any medications? YES○ NO○

If yes, please list: _____

Indicate which of the following you have had or have at present. Mark either "YES" or "NO" next to each item.

Heart Failure	YES○	NO○	Anemia	YES○	NO○	Sinus Trouble	YES○	NO○	Arthritis/Gout	YES○	NO○	Artificial Heart Valve	YES○	NO○	Nervousness	YES○	NO○
Artificial Joints	YES○	NO○	Shortness of Breath	YES○	NO○	Liver Disease	YES○	NO○	Cancer	YES○	NO○	Cortisone Medicine	YES○	NO○	Heart Surgery	YES○	NO○
Chronic Cough	YES○	NO○	Diabetes	YES○	NO○	High Blood Pressure	YES○	NO○	Alzheimer's Disease	YES○	NO○	Hepatitis B (serum)	YES○	NO○	Stroke	YES○	NO○
Blood Transfusion	YES○	NO○	Hay Fever	YES○	NO○	Cosmetic Surgery	YES○	NO○	Arteriosclerosis	YES○	NO○	Parathyroid Disease	YES○	NO○	HIV Positive	YES○	NO○
Angina Pectoris	YES○	NO○	Sickle Cell Disease	YES○	NO○	Radiation Therapy	YES○	NO○	Lung Disease	YES○	NO○	Chest Pain	YES○	NO○	Psychiatric Treatment	YES○	NO○
Kidney Trouble	YES○	NO○	Heart Disease	YES○	NO○	Yellow Jaundice	YES○	NO○	Anti-Cancer Drugs	YES○	NO○	Drug Addiction	YES○	NO○	Valvular Dysfunction	YES○	NO○
Tuberculosis (TB)	YES○	NO○	Thyroid Problems	YES○	NO○	Low Blood Pressure	YES○	NO○	Hypoglycemia	YES○	NO○	Hepatitis C	YES○	NO○	Excessive Thirst	YES○	NO○
Hemophilia	YES○	NO○	Allergies or Hives	YES○	NO○	Emphysema	YES○	NO○	Mitral Valve Prolapse	YES○	NO○	Fainting/Dizzy Spells	YES○	NO○	Swelling of Ankles/Feet/Hands	YES○	NO○
Heart Attack	YES○	NO○	Bruise Easily	YES○	NO○	Chemotherapy	YES○	NO○	Rheumatism	YES○	NO○	Heart Pacemaker	YES○	NO○	Cold Sores/Fever Blisters	YES○	NO○
Ulcers	YES○	NO○	Rheumatic Fever	YES○	NO○	Epilepsy or Seizures	YES○	NO○	Hepatitis A (infect.)	YES○	NO○	Recent Weight Loss	YES○	NO○			
Asthma	YES○	NO○	Glaucoma	YES○	NO○	Blood Disease	YES○	NO○	Herpes	YES○	NO○	AIDS	YES○	NO○			

Do you have any disease, condition, or medical problem not listed above YES○ NO○

If yes, please list: _____

For Women

Are you pregnant? YES○ NO○

Are you nursing? YES○ NO○

Are you taking any birth control pills? YES○ NO○

NOTES:

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

Patient Signature (Parent or Guardian) _____ Date _____