SAN DIEGO

DENTURE & IMPLANT SPECIALISTS

Patient Medical History

Date: _____/_____/_____

Patient's Name: _____

The reason for your visit today: _____

_____

Have you been hospitalized in the past two years? Yes No

Have you been treated by a physician in the past year? Yes No
Physician's Name: _____

Have you taken any prescribed medications or drugs in the past two years?
Yes No

Please list all medications or drugs:

_____

_____

Are you, or have you ever been on any weight reduction medication
(e.g. Fen-Phen)? Yes No

Do you smoke tobacco or chew tobacco? Yes No

Have you ever had problems with a dental local or general anesthetic?
Yes No

Circle if you are allergic to any of the following medications:

Penicillin	Sulfa	Antibiotics	Codeine
Iodine	Aspirin	Latex Gloves	Local Anesthetics

Other: _____

Are you allergic (i.e. itching, rash, swelling) to or made sick by any drugs,
medications or doctor's treatment? Yes No
Explain: _____

Circle if you have or have ever had any of the following:

Heart Disease	**Stroke**	**Glaucoma**
Heart Attack	**Kidney Trouble**	**Pain in Jaw Joints**
Angina	**Ulcers**	**Allergies or Hives**
High Blood Pressure	**Emphysema**	**Hepatitis**
Low Blood Pressure	**Tuberculosis (TB)**	**Liver Disease**
Heart Murmur	**Asthma**	**Yellow Jaundice**
Mitral Valve Prolapse	**Hay Fever**	**Drug or Alcohol Addiction**
Rheumatic Fever	**AIDS or HIV infection**	**Blood Transfusion**
Scarlet Fever	**Diabetes**	**Hemophilia**
Artificial Heart Valve	**Thyroid Disease**	**Venereal Disease**
Heart Pacemaker	**Leukemia**	**Epilepsy or Seizures**
Congenital Heart Defects	**Cortisone Medication**	**Nervousness**
Heart Surgery	**Radiation Treatment**	**Sickle Cell Disease**
Prosthetic Joint	**Chemotherapy**	**Bruise Easily**
Anemia	**Arthritis**	**Psychiatric Treatment**
Rheumatism	**Prosthetic Joint**	**Fainting or Dizzy Spells**
Sinus Trouble	**Cancer**	**Lupus**

Do you have any disease(s) and/or conditions not listed? **Yes** **No**

Women:	**Are you pregnant?**	**Yes**	**No**
	Do you anticipate becoming pregnant?	**Yes**	**No**
	Are you taking birth control medication?	**Yes**	**No**

To the best of my knowledge, all of the preceding answers are true and correct. If any changes occur pertaining to my health or if my medications change, I will inform Dr. Peter F. Johnson at the next appointment.

Patient's Signature	Doctor's Signature	Date