Joseph P. Thornton, D.D.S.

Patient Name_____ **Date of Birth**_____
The following information is essential for this office to provide your care in a manner that is compatible with your general health. ***Incorrect information can be dangerous to your health.***

Name of your Medical Doctor_____ Phone #_____
Date and Reason for Your Last Visit_____

MEDICAL HISTORY:

*Circle the answer to each question in the area provided
*If you are unsure of any answer, indicate so and discuss it with our staff
*Please answer all questions

DO YOU NOW, OR HAVE YOU EVER HAD, ANY OF THE CONDITIONS LISTED:

yes no Rheumatic fever, rheumatic heart disease, congenital heart disease
yes no Heart murmur, irregular heartbeat, or mitral valve prolapse
yes no Heart attack, angina, heart surgery, pacemaker or other heart problems
yes no High or low blood pressure, excessive bleeding, or anemia
yes no Diabetes, or high or low blood sugar
yes no Hepatitis, jaundice, or liver disease
yes no Stomach or intestinal disorder, or ulcers
yes no Breathing or sinus problems, asthma, or tuberculosis
yes no Cancer, radiation therapy, chemotherapy: cancer type_____date_____
yes no Kidney problems or dialysis
yes no AIDS, positive HIV status, or venereal disease
yes no Stroke, convulsions, epilepsy, fainting spells, or seizures
yes no Tumors or growths
yes no Eye surgery or glaucoma
yes no Arthritis, rheumatism, inflammatory joint disease, or fibromyalgia
yes no Artificial joints (Knee or Hip replacement, etc)
yes no Do you smoke or use tobacco products?
yes no Do you habitually use any controlled substances?
yes no Do you suffer memory loss, disorientation, alzheimers or any mental impairment?
yes no Have you ever been advised to take antibiotics prior to dental treatment?
yes no Are you allergic to any medications?_____
yes no Are you allergic to latex, or any metal, chemical or environmental agents?_____

yes no Have you had any serious operations or head/neck injuries? Describe_____
_____

yes no Are you under a physician or specialist's care? For what reason_____
_____

yes no Please list, or provide a list, of any medications that you currently take_____
_____

yes no Is there anything else that we should know about your health that is not listed on this form?
_____

Signature of Patient or Guardian_____ **Date**_____

Reviewed by:_____ Date_____
