FOREST FAMILY DENTISTRY

703-671-8431 ffd3608@yahoo.com

PATIENT NAME: _____ TODAY'S DATE: _____

HOME ADDRESS: _____ DATE OF BIRTH: _____

_____ **SS#:** _____

EMAIL ADDRESS: _____ CELL PHONE: _____

WORK ADDRESS: _____ WORK PHONE: _____

_____ HOME PHONE: _____

INSURANCE: _____

Policy Number _____ **Member ID #** _____

Policy Holder Name: _____

PATIENT MEDICAL HISTORY

PHYSICIAN: _____ Office Phone: _____ Last Exam Date: _____

	YES	NO
1. Are you under medical treatment now?		
2. Have you ever been hospitalized for any surgical operation or serious illness?		
3. Are you taking any medication(s) including non-prescription medicine?		

If yes, list medication(s) you are taking: _____

_____

_____

_____

8. Are you allergic to or have you had any reations to the followings?

Yes	No		Yes	No		Yes	No	
		Local anesthetics (eg. Nonvocaine)			Barbiturates			Aspirin
		Penicillin or other antibiotics			Sedatives			Other
		Sulfa Drugs			Lodine			

	Yes	No
4. Have you ever taken Fen-Phen/Redux?		
5. Do you use tobacco?		
6. Do you use alcohol, cocaine or other drugs?		
7. Are your wearing contact lenses?		

	Yes	No
9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?		
10. WOMEN ONLY:		
a) Are you pregnant or think you may be pregnant?		
b) Are you nursing?		
c) Are you taking birth control pills?		

10. Do you have or have you had any of the followings?

Yes	No		Yes	No	
		High Blood Pressure			Leukemia
		Heart Attack			Low Blood Pressure
		Heart Disease			Rheumatic Fever
		Heart Murmur			Sexual Transmitted Disease
		Cardiac Pacemaker			Stomach Troubles / Ulcers
		Anemia			Swollen Ankles
		Angina			Thyroid Problem
		Arthritis			Chest Pain
		Asthma			Easily Winded
		AIDS or HIV Infection			Glaucoma
		Cancer			Hay Fever / Allergies
		Emphysema			Heart Trouble
		Epilepsy / Convuisions			Liver Disease
		Fainting / Seizures			Radiation Therapy
		Frequently Tired			Respiratory Problems
		Diabetes			Recent Weight Loss
		Hepatitis / Jaundice			Stroke
		Joint Replacement or Implant			Turberculosis
		Kidney Diseases			Other _____

COMMENTS:

Signature of Dentist _____

Date

Patient/Guardian Signature and Date: X _____