Jack Schwartz D.D.S.

Patient Medical History

Please select an answer for each of the following.

Are you allergic to any of the following?

Local anesthetics	Yes	No	Don't Know
Aspirin	Yes	No	Don't Know
Penicillin/Amoxicillin	Yes	No	Don't Know
Erythromycin	Yes	No	Don't Know
Tetracycline	Yes	No	Don't Know
Sulfa Drugs	Yes	No	Don't Know
Codeine	Yes	No	Don't Know
Acetaminophen	Yes	No	Don't Know
Fluoride	Yes	No	Don't Know
Iodine	Yes	No	Don't Know
Latex	Yes	No	Don't Know
Barbiturates, sedatives	Yes	No	Don't Know
Any other medication	Yes	No	Don't Know

Are you required to take any premedication prior to dental treatment?

If yes, for what condition?_____

Female:

Taking birth control	Yes	No
Pregnant		

Male:

Prostrate disorders

Name of Physician_____

Date of most recent physical_____

Do you have any of the following conditions?

Abnormal bleeding	Yes	No	Don't Know
AIDS/HIV	Yes	No	Don't Know
Anemia	Yes	No	Don't Know
Arthritis	Yes	No	Don't Know
Asthma	Yes	No	Don't Know
Cancer	Yes	No	Don't Know
Chemotherapy/Radiation therapy	Yes	No	Don't Know
Angina	Yes	No	Don't Know
Arteriosclerosis	Yes	No	Don't Know
Artificial heart valves	Yes	No	Don't Know

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Congenital heart defects	Yes	No	Don't Know
Congestive heart failure	Yes	No	Don't Know
Coronary artery disease	Yes	No	Don't Know
Damaged heart valves	Yes	No	Don't Know
Heart attack	Yes	No	Don't Know
Heart murmur	Yes	No	Don't Know
High blood pressure	Yes	No	Don't Know
Low blood pressure	Yes	No	Don't Know
Mitral valve prolapse	Yes	No	Don't Know
Pacemaker	Yes	No	Don't Know
Rheumatic heart disease	Yes	No	Don't Know
Chest pain upon exertion	Yes	No	Don't Know
Chronic pain	Yes	No	Don't Know
Chronic fatigue syndrome	Yes	No	Don't Know
Diabetes If so, specify below:	Yes	No	Don't Know
___Type I (Insulin dependent) ____ Type II	Yes	No	Don't Know
Dry mouth	Yes	No	Don't Know
Eating disorder	Yes	No	Don't Know
Epilepsy	Yes	No	Don't Know
Fainting spells	Yes	No	Don't Know
Gastrointestinal disease	Yes	No	Don't Know
G.E. Reflux	Yes	No	Don't Know
Glaucoma	Yes	No	Don't Know
Hemophilia	Yes	No	Don't Know
Hepatitis, jaundice or liver disease	Yes	No	Don't Know
Heavy smoker	Yes	No	Don't Know
Head or neck injuries	Yes	No	Don't Know
Kidney problems	Yes	No	Don't Know
Mental health disorders	Yes	No	Don't Know
Malnutrition	Yes	No	Don't Know
Night sweats	Yes	No	Don't Know
Neurological disorders	Yes	No	Don't Know
Osteoporosis	Yes	No	Don't Know
Persistent swollen glands in neck	Yes	No	Don't Know
Respiratory problems	Yes	No	Don't Know
Emphysema	Yes	No	Don't Know
Bronchitis	Yes	No	Don't Know
Severe headaches/Migraines	Yes	No	Don't Know
Sexually transmitted disease	Yes	No	Don't Know

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Sinus trouble	Yes	No	Don't Know
Sleep disorder	Yes	No	Don't Know
Sores or ulcers in the mouth	Yes	No	Don't Know
Stroke	Yes	No	Don't Know
Systemic lupus erythematosus	Yes	No	Don't Know
Tuberculosis	Yes	No	Don't Know
Thyroid or parathyroid problems	Yes	No	Don't Know
Ulcers	Yes	No	Don't Know
Excessive urination	Yes	No	Don't Know

Describe any current medical treatment including drugs taken, even though not listed above_____

_____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc which still has to be paid whether you are present or not. Once an appointment has been made, please remember this time has been reserved for you.

Signature_____

(Parent or Guardian, if patient is a minor)

Date_____

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