TEPE FAMILY DENTISTRY

GENERAL DENTISTS

Patient's name ______________________ Today's Date ______________

Date of Birth ______________ Name and phone number of usual pharmacy ______________________

Do you have an allergy to any type of antibiotic? If yes, list here ______________________

1. Are you under the care of a physician at this time? .... YES NO

   If yes, for what condition? ______________________

2. The name and address of my physician is: ______________________

3. My last physical exam was on ______________

4. Has a physician treated you in the past six months? .... YES NO

   If yes, for what condition? ______________________

5. Have you been hospitalized or had a serious illness within the last five years? .... YES NO

   If yes, please specify: ______________________

6. Are you allergic or had any adverse reaction to any medicines, drugs, local anesthetics, LATEX or other substances? .... YES NO

   If yes, please specify: ______________________

7. Do you have or have you had any of the following diseases/problems? Please explain YES answers on the back

	Condition				Condition		
A.	Abnormal bleeding, bruise easily or require blood transfusion	YES	NO	Q.	Artificial/Prosthetic heart valves	YES	NO
B.	Angina/Chest Pain	YES	NO	R.	Valve damage following heart transplant	YES	NO
C.	Asthma/Lung/Respiratory condition	YES	NO	S.	Congenital heart defect	YES	NO
D.	Diabetes	YES	NO	T.	Infective endocarditis	YES	NO
E.	Emotional/Mental health disorder	YES	NO	U.	Heart Murmur	YES	NO
F.	Epilepsy/seizures/convulsions	YES	NO	V.	Mitral valve prolapsed	YES	NO
G.	Hepatitis/Jaundice/Cirrhosis/Liver disease	YES	NO	W.	Rheumatic heart disease	YES	NO
H.	High blood pressure	YES	NO	X.	Congestive heart failure	YES	NO
I.	HIV positive/AIDS	YES	NO	Y.	Pacemaker	YES	NO
J.	Hives or skin rash	YES	NO	Z.	Cardiovascular (heart) disease, arteriosclerosis, coronary occlusion	YES	NO
K.	Kidney/Renal disease	YES	NO	AA.	Cancer/Chemo/Radiation therapy	YES	NO
L.	Sexually Transmitted Disease(s)	YES	NO	BB.	Immune suppression or deficiency	YES	NO
M.	Stomach ulcers	YES	NO	CC.	Heart attack Date	YES	NO
N.	Thyroid Disease	YES	NO	DD.	Heart surgery Date	YES	NO
O.	Tuberculosis	YES	NO	EE.	Stroke Date	YES	NO
P.	Artificial/Prosthetic joint replacement	YES	NO	FF.	GERD (gastric esophageal reflux disease)	YES	NO

Please turn page to complete form