

PATIENT MEDICAL HISTORY

Please Print Legibly

SHELDON R. MANN, D.D.S., P.A.

Mr., Mrs., Ms., Last Name		Family Dentist	
First Name	Middle Initial	Family Physician	Date of Last Physical Exam
Home Street Address		City & State	Zip Code
Home Phone ()		Work Phone ()	Cell Phone ()
HOW DID YOU HEAR ABOUT OUR PRACTICE? ___ Web page ___ doctor (name _____) ___ Friend (name _____) ___ other (_____)			
Date of Birth	Social Security Number	Today's Date	Sex Male Female

- Yes No
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth.
2. Has there been any change in your general health within the past year? If yes, explain.
3. Are you under the care of a physician for a current problem? If yes, explain.
4. Have you been hospitalized within the past 5 years? Please specify.
5. Have you received therapy for alcoholism or drug addiction during the past 5 years?
6. Have you ever had any **ALLERGIC OR ADVERSE REACTION to anesthetics/antibiotics/medications**? Please list.
7. Is there any condition concerning your health that the doctor should know?
8. Have you had abnormal bleeding with previous extraction's, surgery or trauma? Do you bruise easily?
9. Have you ever required a blood transfusion?
10. Have you ever had surgery and/or radiation/chemotherapy for a cancer tumor, growth or other condition?
11. Have you ever tested positively for HIV infection or AIDS? If so, date diagnosed and treating Dr.
12. ARE YOU REQUIRED TO TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT? ie: Heart Condition, Joint Replacement

13. Do you have, or have you had any of the following? (ONLY MARK BOXES THAT APPLY)

- | | | |
|---|---|--|
| <input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart murmur or Mitral Valve Prolapsed
<input type="checkbox"/> Joint prosthesis/replacement (hip, knee, etc.)
<input type="checkbox"/> Rheumatic fever or rheumatic heart disease
<input type="checkbox"/> Congenital heart disease
<input type="checkbox"/> Heart attack, stroke or bypass
<input type="checkbox"/> Prosthetic (artificial) heart valve
<input type="checkbox"/> Blood Disorder e.g., anemia
<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Asthma
<input type="checkbox"/> Allergy to Latex/sulfa/aspirin/penicillin
(Please Circle) | <input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Chest pain, angina
<input type="checkbox"/> Swollen ankles, arthritis or joint disease
<input type="checkbox"/> Cardiac pacemaker
<input type="checkbox"/> Heart surgery
<input type="checkbox"/> Delay in healing
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Emphysema or Lung Problems
<input type="checkbox"/> Eye disease or glaucoma
<input type="checkbox"/> Sinus Trouble/Hay Fever
<input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Stomach ulcers, colitis
<input type="checkbox"/> Hepatitis, Jaundice, Liver disease
<input type="checkbox"/> Kidney problems/Dialysis
<input type="checkbox"/> Psychiatric treatment
<input type="checkbox"/> Fainting spells
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> TMJ Joint problems
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Immune system problems
<input type="checkbox"/> None of the Above |
|---|---|--|

- Yes No
14. Women only: Are you pregnant, nursing or on birth control pills? *Antibiotics may alter effectiveness of birth control pills
15. Do you have any disease, condition or problem not listed above? Specify

16. PLEASE LIST YOUR MEDICATIONS:

17. EMERGENCY CONTACT

NAME PHONE #

X
Signature (Please see other side)