Dr. Drew Beaty Personal and Innovative Care Today's Date: _____

Patient Medical Information

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

Name: _____ Age: _____ Date of Birth: _____

Physician's Name and Address: _____

_____

Physicians Phone: _____ Date of last visit: _____

ALLERGY PROBLEMS

Asthma	Yes	No
Hay Fever	Yes	No
Sinus Problems	Yes	No
Skin Rashes	Yes	No

BLOOD PROBLEMS

Abnormal Bleeding	Yes	No
Blood Disease/Anemia	Yes	No
Easy Bleeding	Yes	No
Frequent Nosebleeds	Yes	No

BONE OR JOINT PROBLEMS

Arthritis	Yes	No
Joint Replacement	Yes	No
Osteoporosis	Yes	No
Back or Neck Pain	Yes	No

HEART PROBLEMS

Chest Pain	Yes	No
Heart Murmur	Yes	No
Heart Valve Problem	Yes	No
High Blood Pressure	Yes	No
Pacemaker	Yes	No
Rheumatic Fever	Yes	No
Shortness of Breath	Yes	No
Heart Attack	Yes	No
If yes, date:		
Stroke	Yes	No
If yes, date:		

INTESTINAL PROBLEMS

Special Diet	Yes	No
Ulcers	Yes	No
Weight Gain/Loss	Yes	No

OTHER

Cancer/Tumor	Yes	No
Treatment dates:		
Diabetes	Yes	No
Epilepsy/Seizures	Yes	No
Glaucoma	Yes	No
Hepatitis	Yes	No
If yes, type:		
Other Liver Problems	Yes	No
If yes, type:		
Herpes	Yes	No
HIV/AIDS	Yes	No
Tuberculosis	Yes	No
Other Respiratory Problems	Yes	No
Venereal Disease	Yes	No
Do you smoke?	Yes	No
If yes, how much?		
Do you consume alcohol?	Yes	No
If yes, how much?		

Are you seeing a physician for the treatment of a medical condition?

Have you been hospitalized in the last year?

Have you ever been advised to take an antibiotic prior to a dental appointment?

WOMEN

Are you pregnant?	Yes	No
If yes, approx. due date:		
Are you taking contraceptives?	Yes	No
Other hormones?	Yes	No

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ALLERGIES

Are you allergic to or have you reacted adversely to any of the following?

Local Anesthetics	Yes	No
Penicillin or other antibiotics	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Sedatives or sleeping pills	Yes	No
Aspirin	Yes	No
Acetaminophen	Yes	No
Ibuprofen	Yes	No
Codeine	Yes	No
Metals	Yes	No
Latex	Yes	No

Other:

_____

_____

MEDICATIONS

List medications you are currently taking, both prescription and over the counter:

_____

_____

_____

_____

_____

_____

_____

Are you currently taking any herbal or natural homeopathic remedies?

OTHER MEDICAL PROBLEMS OR CONDITIONS

_____

_____

_____

_____

_____

_____

_____

NOTES:

I certify that the above information is complete and accurate.

Signature: _____

Date: _____

Dentist's Signature: _____

Date: _____