DONOHUE & DONOHUE D.D.S., PC
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PATIENT MEDICAL HISTORY

Name:____ Soc. Sec. #: ______________________
(First) (MI) (Last)

Preferred Name/Nickname (if any): ________________________ Date of Birth : ____________M_____F_____

Medical History:
Do you consider yourself to be in good health? **YES NO**
Have you been hospitalized or had a serious illness/injury within the past year? **YES NO**
If yes please explain: ___________________________
Women Only: Are you Pregnant or trying to get pregnant **YES NO** Nursing? **YES NO**
If yes, how many weeks ___________________________

Do you have, or have had, any of the following? Please check if YES

__Abnormal Bleeding
__Alcoholism
__Alzheimers or Dementia
__Anemia
__Artificial Heart Valve
__Artificial Joints
__Arthritis
__Asthma
__Autism
__Bariatric Surgery
__Blood Disorder or Hemophilia
__Blood Transfusion
__Cancer
__Chemotherapy
__Chest Pains
__Cold/Canker Sores
__Colitis
__ COPD
__Diabetes
__Depression/Anxiety
__Epilepsy or Seizures
__Fainting or Dizziness
__Glaucoma
__Headaches
__Hearing Disorder
__Heart Disease or Heart Attack
__Heart Stents
__Hepatitis A B C (circle one)
__High Blood Pressure
__HIV/Aids
__Kidney Problems
__Learning Disability
__Liver Disease
__Pacemaker
__Psychiatric Care
__Radiation Therapy or Treatment
__Smoker or Tobacco User
__Stroke
__Thyroid Disease
__Tuberculosis
__Ulcers
___ Heart Surgery

Do you take Bisphosphonates (Osteoporosis Medications such as Reclast, Fosomax)? ____________

If you answered YES to any of the above please explain____

Is there any other disease/condition or problem that is not listed above, including prior
surgeries____
____

____
Dental History
When was the last time you visited a dental office?______________________________________

Are you allergic to any of the following? (Please Circle)

Penicillin **Red Dye**
Codeine
Erythromycin
Latex
Dental Anesthetics
Sulfa
Jewelry
Tetracycline
Other:_______________________
If yes to any of the above please explain reaction that occurs.______________________________

Please list any medications you are currently taking
(Include Over the Counter, Vitamins and natural remedies)

_______________ _____________________
_______________ _____________________
_______________ _____________________
_______________ _____________________

Patient Signature____ Today's Date______________________