COVINGTON PIKE DENTAL CLINIC
FRED C. HEROS, D.D.S.

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Medical history for:

Patient Name _____ **Nickname** _____ **Date of Birth** _____

Are you allergic to any of the following?

Latex___ Penicillin___ Amoxicillin___ Aspirin___ Ibuprofen___ Codeine___ or any reaction to a substance or medication not listed? _____

Have you ever had a reaction after receiving dental anesthetic or dental treatment? ___Yes ___ No

Explain reaction: _____

Are you currently pregnant? Yes___ No ___ **DUE DATE:** _____

HAVE YOU BEEN HOSPITALIZED? ___YES ___ NO **WHEN?** _____

For What Condition? _____

Please check yes or no to the following medical conditions & date when the condition occurred:

	Yes	No	Date		Yes	No	Date
Heart Attack	___	___	_____	Cancer / Tumors	___	___	_____
Stroke	___	___	_____	Chemotherapy	___	___	_____
Heart Surgery	___	___	_____	Radiation Treatment	___	___	_____
Angina / Chest Pain	___	___	_____	Leukemia	___	___	_____
Heart Murmur	___	___	_____				
Pacemaker / Defibrillator	___	___	_____	Artificial Joints	___	___	_____
Congenital Heart Defect	___	___	_____	Arthritis	___	___	_____
Artificial Valves	___	___	_____	Rheumatism	___	___	_____
Mitral Valve Prolapse	___	___	_____	Jaw Problems / TMJ	___	___	_____
High / Low Blood Pressure	___	___	_____				
				Bleeding Problems	___	___	_____
Allergies	___	___	_____	Diabetes / Hypoglycemia	___	___	_____
Asthma	___	___	_____	Hepatitis	___	___	_____
Breathing Problems	___	___	_____	Kidney Disease	___	___	_____
Respiratory Disease	___	___	_____	Liver Disease	___	___	_____
Sinus Problems	___	___	_____	Rheumatic Fever	___	___	_____
Tuberculosis TB	___	___	_____	Scarlet Fever	___	___	_____
				Shingles / Chicken Pox	___	___	_____
Eating Disorders	___	___	_____	Thyroid Problems	___	___	_____
Drug / Alcohol Abuse	___	___	_____	Herpes	___	___	_____
Tobacco Use	___	___	_____	Venereal Disease	___	___	_____
HIV	___	___	_____	Mental Disorders	___	___	_____
AIDS	___	___	_____	Nervous Disorders	___	___	_____
Dizziness	___	___	_____	Stomach Problems	___	___	_____
Seizure Disorder	___	___	_____				
Fainting	___	___	_____	Are you taking a blood thinner?	___	___	_____
Head Injuries	___	___	_____				

Please list any medical conditions you have ever had that are not listed above:

_____

_____

Please list any medications you are currently taking (including herbal medications / vitamins):

_____

_____

_____

Have you ever taken the drug Phen-fen or Redux? Yes___No ___

Signature _____ (if parent or guardian, please circle) Date _____