Signature SMILES
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Medical History

All information is confidential.

Health problems you may have, or medication you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following pertinent questions truthfully.

Patient Name:_____ Date of Birth:_____

Physician's Name:_____ Physician's Phone #:_____

Preferred Pharmacy:_____

1. Are you presently, or have you recently been under the care of a physician for any condition or serious ailment? NO YES Please explain:_____
2. Have you ever had a serious illness or accident requiring hospitalization or extensive medical care? NO YES Please specify:_____
3. Has there been any change in your general health in the past year? NO YES please explain: _____
4. Do you have any conditions or undergoing any therapies that could affect your immune system? (i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? NO YES
5. Do you have a bleeding disorder or are you on blood thinners? NO YES
6. Do you have or have you ever had a replacement or repair of heart valve, heart transplant, an infection of the heart (i.e. Infective endocarditis) or a heart condition from birth (i.e. Congenital heart disease)? NO YES
   Please specify: _____
7. Do you have any prosthetic or artificial joints? NO YES _____
8. Have you ever been told you require antibiotics prior to dental treatment? NO YES
9. Do you smoke or chew tobacco products? NO If YES, for how many years:_____

10. Do you use any prescription, non-prescription, or recreational drugs/medications?
If so, please list below.

Drug_____Reason_____Drug_____Reason_____
Drug_____Reason_____Drug_____Reason_____

11. Have you ever experienced any unusual or allergic reaction to any of the following?

Local anaesthesia Sulfa Drugs Latex/Rubber Aspirin(ASA)
Erythromycin Barbiturates Penicillin Metal(nickel) Codeine

12. Do you have or have you ever had any of the following? (Please circle those applicable)

Fainting or dizziness	HIV positive/testing	Back Problems
Malignant hyperthermia	Mental/nervous disorder	Heart attack/Stroke
Kidney/liver disease	High/Low Blood pressure	Thyroid disease
Hepatitis A,B or C	Stomach/intestinal problems	Diabetes
Organ/Medical implants	Hyperglycemia/hypoglycemia	Epilepsy/Seizures
Drug/Alcohol addiction	Pacemaker/implanted defibrillator	

13. Do you have any other disease, condition or problem that you think the doctor should know about? NO YES
Please explain:_____

14. Women only: Taking Birth Control pills Nursing Pregnant what month?_____

PATIENT (GUARDIAN) CONSENT AND APPROVAL

I, the undersigned, certify that all of the medical and dental information is true to my knowledge and I have not omitted any pertinent information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary and consent to my physician being contacted if necessary.

Patient (Parent, Guardian) Signature_____**Date(D/M/Y)**_____