Medical Information

Physician's Name: _____

City: _____

Phone: (____)_____-_____

General Health: Excellent Good Fair Poor

When was your last complete physical? _____

Are you presently taking any medications?
Please list:

Have you ever taken Fen-Phen? Y N

Do you use recreational drugs? Y N
Please list:

Are you allergic to?

Penicillin Novocaine Codeine Latex

Other:

Have you ever been hospitalized? Y N

Have you ever had abnormal bleeding after any surgical procedure, including extractions? Y N

Please check any of the following that you have ever had or been treated for:

- ☐ surgical implant: Joint Breast Other
- ☐ rheumatic fever or rheumatic heart disease
- ☐ heart murmur
- ☐ heart disorder
- ☐ heart attack
- ☐ prosthetic valve, mitral valve prolapse
- ☐ stroke
- ☐ swollen ankles
- ☐ difficulty breathing
- ☐ asthma or hay fever
- ☐ allergies
- ☐ rapid weight gain or loss
- ☐ thyroid disease or malfunction
- ☐ kidney disease or malfunction
- ☐ epilepsy
- ☐ frequent headaches or earaches
- ☐ tuberculosis
- ☐ glaucoma
- ☐ anemia, blood disorder, AIDS, HIV+, other
- ☐ cancer
- ☐ diabetes
- ☐ family history of diabetes
- ☐ ulcer or other gastrointestinal problems
- ☐ Women: are you pregnant?
- ☐ Women: do you take birth control pills?
- ☐ Women: do you take estrogen?
- ☐ Women: do you take calcium supplements?

Please Sign and Date

The information I provided on this form is accurate to the best of my knowledge. If there are any changes in my medical status, I will inform the periodontist and his staff. I give the periodontist and his staff permission to share x-rays and other information as needed for my treatment from my physician, dentist and insurance companies. I understand that this information is confidential and will be protected by the privacy practices as stated in the Notice of Privacy Practices, available upon request or on our website, HappyGums.com.

I am aware that I am ultimately responsible for my account regardless of my insurance benefits. I agree to pay Dale R. Johnstone, D.D.S. any unpaid balance upon completion of treatment unless other arrangements have been made.

Signature _____ Date _____

Name (Print): _____