Wm. B Keskimaki DDS

MEDICAL HISTORY

Physician's Name ______________________________ Date of last visit ____________________

Please check yes or no to indicate if you have had any of the following:

Condition	
AIDS	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No
Artificial heart valves	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No
Bleeding abnormally (with extractions or surgery)	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Chemical dependency	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No
Circulatory problems	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No
Cortisone treatments	☐ Yes ☐ No
Cough, Persistent or bloody	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Do you wear Contact lenses	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Headaches	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No
Type __________	
Herpes	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Meds: ____________________	
HIV Positive	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No
Jaw Pain	☐ Yes ☐ No
Joint replacement	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No
Nervous Problems	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Women:	
Are you pregnant?	☐ Yes ☐ No
Due date __________	
Are you nursing?	☐ Yes ☐ No
Are you taking birth control pills?	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No
Radiation Treatment	☐ Yes ☐ No
Respiratory Disease	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
Scarlet Fever	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No
Sinus Trouble	☐ Yes ☐ No
Skin Rash	☐ Yes ☐ No
Special Diet	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Swelling of Feet or ankles	☐ Yes ☐ No
Swollen Neck Glands	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No
Tonsillitis	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Tumor or growth on Head or Neck	☐ Yes ☐ No
Ulcer	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No
Weight Loss, unexplained	☐ Yes ☐ No
Any hospital stays	☐ Yes ☐ No

Explain ______________________________

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MEDICATIONS

Please list medications you are currently taking:

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____

Pharmacy Name ______________________

Phone ______________________

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other __________

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I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

______________________________ ____________________

Patient's Signature Date

Original