Michael D. Doyle, D.D.S., LLC

MEDICAL / DENTAL HISTORY:

Personal Physician______________________**Address**__________________________________**Phone**_____________

Accurate and complete disclosure of medical information is necessary for proper diagnosis and to help prevent unnecessary complications during your treatment. Please check the box for any condition that you have now or had in the past. **(Parent / Guardian: Please check the appropriate boxes concerning your child's health status.)**

Cardiovascular (Heart)

- High Blood Pressure ☐
- Heart Attack ☐
  - When?__________________
- Heart Pacemaker
- Heart Surgery
- Irregular Heart Beat
- Heart Murmer
  - Premed?________________
- Mitral Valve Prolapse
  - Premed?________________
- Rheumatic Fever
  - Premed?________________
- Angina/Chest Pain
  - When Last?_____________
- Congenital Heart Defect
- Take Daily Aspirin
- Take Coumadin
- ANY blood thinners

Dermal/Musculoskeletal

- Allergy to Latex
- Sore Jaw Muscles/Joints
- Arthritis
- Artificial Joints
  - Premed?________________
- Mouth Ulcers/Sores

Nerves & Sensory

- Severe Headaches
- Fainting / Dizzy Spells
- Epilepsy / Seizures
- Nervousness
- Dental Anxiety

Respiratory (Breathing)

- Sinus Problems
- Allergies or Hives
- Asthma
  - Use Inhaler?______________
  - How Often?______________
- Tuberculosis (TB)
- Endocrine (Hormonal)
- Diabetes
  - Take Insulin?_____________
- Thyroid Disease

Other Conditions

- Enlarged Node/Gland
- Use Tobacco
- Use Alcohol
- Drug Dependency
- Tumor / Cancer
- Radiation / Chemotherapy

Gastrointestinal (Stomach)

- Ulcers
- Hepatitis
  - When?___________________
  - What Type?_______________
- Liver Disease
- Cirrhosis

Hematologic (Blood)

- Stroke
  - When?___________________
- Anemia
- Prolonged Bleeding
- Leukemia
- HIV / AIDS

Urinary

- Urinate Frequently
- Kidney Problem

*Please list any other medical conditions or concerns not mentioned above that the Doctor should be aware of:*___________________

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Have you seen a physician for a medical condition in the last 6 months?____

Are you taking (or supposed to be taking) any medicine, drug or pills of any kind (including Aspirin and other non-prescription drugs). If so, what?____

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Are you allergic to any drugs or medicines? Yes____ No____ If so, what drug and what type of reaction did you have?___________

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Have you ever had root canal treatment before?_________ Have you ever had a reaction to dental anesthetic?____________________

WOMEN: Are you pregnant? ______________ How far along? (circle one) 1-3 months 3-6 months 6-9 months

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment.

Patient, Parent or Guardian Signature: ____ **Date:** ____________________