Seattle's Downtown Dentist
Patient's Medical Information

Patient's Name_____ Date of Last Physical Exam_____

Physician's Name_____ Physician's Phone # _____

Patient's Medical History

1. Are you under medical treatment now?.....YES NO

   If so, what?_____

2. Have you been hospitalized for any surgical operations or serious illness?.....YES NO

   If so, what?_____

3. Are you taking any medicines including non-prescription medicine?.....YES NO

   If so, what?_____

4. Have you ever been diagnosed with obstructive sleep apnea?.....YES NO

   If so, when?_____

Allergies to Medicines ☐ **No Known Allergies**

Are you allergic to or have you had any reactions to the following?

☐ Local Anesthetics (i.e. Novocain) ☐ Sulfa Drugs ☐ Codeine ☐ Latex ☐ Sedatives

☐ Penicillin / Amoxicillin ☐ Ibuprofen ☐ Barbiturates ☐ Aspirin

☐ Other _____

Please check the boxes if you have or have had any of the following

☐ Joint Replacement/Implants/Screws/Pins	☐ Anemia	☐ Cancer / Radiation Therapy
☐ History of Tobacco Use	☐ Emphysema	☐ Kidney / Liver Disease
☐ Heart Murmur	☐ Cardiac Pacemaker	☐ Angina / Chest Pains
☐ Heart Attack / Heart Disease	☐ Rheumatic Fever	☐ Hepatitis / Jaundice
☐ High Blood Pressure	☐ Fainting / Seizures	☐ Epilepsy / Convulsions
☐ Low Blood Pressure	☐ Recent Weight Loss	☐ Leukemia
☐ Asthma	☐ Diabetes	☐ Thyroid Problems
☐ Respiratory Problems	☐ Tumors or Growths	☐ Stomach Troubles / Ulcers
☐ Stroke	☐ Hay Fever / Seasonal Allergies	☐ Intestinal Disease
☐ Tuberculosis	☐ Weight Reduction Surgery	☐ AIDS / HIV Infection

☐ Night Sweats accompanied by weight loss or cough ☐ Wounds that heal slowly or present with other complications

☐ Have you been treated for Alcohol or Chemical dependency? ☐ Snoring while sleeping

Women Only: ☐ Pregnant or think you may be pregnant ☐ Nursing ☐ Taking Birth Control Pills

What is your main reason for visiting our office?_____

Patient/Guardian Signature: _____ Date:_____

Dentist's Signature:_____ Date:_____