Wohlers FAMILY DENTISTRY

3733 Canton Rd. Marietta, GA 30066
Phone: 770.926.9914
www.wohlersdentistry.com

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?……..❒ Yes ❒ No
   If yes: for what reason?_____
   Please provide the name, address, and telephone number of your physician.
   _____
   _____
2. Have you been a patient in the hospital during the past five years?……..……..❒ Yes ❒ No
   If yes: for what reason?_____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?
   ❒ Yes ❒ No If yes, please list:_____
   _____
4. Have you taken any medicine or drugs during the past two years? If yes, please list: ……..……❒ Yes ❒ No
   _____
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ❒ Yes ❒ No
   If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues? ……..❒ Yes ❒ No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication?……..……..❒ Yes ❒ No
7. Are you on a special diet?……..……..……❒ Yes ❒ No
8. Check any of the following, which apply in either past or present:

❒ Heart (Surgery, Disease, Attack)	❒ Latex Sensitivity	❒ Tumors
❒ Chest Pain	❒ Ulcers	❒ Hepatitis A B C (circle)
❒ Congenital Heart Disease	❒ Kidney Trouble	❒ Venereal Disease
❒ Heart Murmur	❒ Diabetes	❒ A.I.D.S./H.I.V. Positive
❒ High/Low Blood Pressure	❒ Thyroid Problems	❒ Cold Sores / Fever Blisters
❒ Mitral Valve Prolapse	❒ Glaucoma	❒ Blood Transfusion
❒ Artificial Heart Valve / Pacemaker	❒ Contact Lenses	❒ Hemophilia
❒ Artificial Joints (hip, knee, etc.)	❒ Emphysema	❒ Sickle Cell Disease
❒ Bleeding Problems	❒ Chronic Cough	❒ Bruise Easily
❒ Rheumatic Fever	❒ Tuberculosis	❒ Liver Disease / Yellow Jaundice
❒ Arthritis/Rheumatism	❒ Asthma	❒ Neurological Disorders
❒ Cortisone Medicine	❒ Hay Fever / Allergies / Hives	❒ Epilepsy or Seizures
❒ Swollen Ankles	❒ Sinus Trouble	❒ Fainting or Dizzy Spells
❒ Stroke	❒ Radiation Therapy	❒ Nervous / Anxious
❒ Diet (Special / Restricted)	❒ Chemotherapy	❒ Psychiatric / Psychological Care

9. Do you have any disease, condition or problem not listed? If so, please list……..…..….❒ Yes ❒ No
   _____
   _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes_____Months No **Nursing?** ❒ Yes ❒ No
11. Do you use birth control prescriptions?…….…… ❒ Yes ❒ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature_____Date _____