DUHON
FAMILY DENTISTRY

Name: _____ Date of Birth: _____

Medical History

Allergies:

Aspirin: Yes No
Codeine: Yes No
Latex: Yes No
Local Anesthetic: Yes No
Penicillin: Yes No
Sulfa: Yes No
List any other allergies: _____

Medical Conditions:

Abnormal (High/Low) Blood Pressure: Yes No

AIDS/HIV: Yes No

Anemia / Bleeding Problems: Yes No

Artificial Heart Valves: Yes No

Blood Disease: Yes No

Congenital Heart Lesions: Yes No

Heart Problems: Yes No

Pacemaker: Yes No

Arthritis / Rheumatism / Gout: Yes No
Artificial Joints / Bones: Yes No

Asthma: Yes No
Cancer: Yes No
Chemotherapy: Yes No
Diabetes: Yes No
Emphysema: Yes No
Glaucoma: Yes No
Radiation Treatment (X-Ray/Cobalt) : Yes No
Shortness of Breath (Breathing Problems) : Yes No
Sinus Trouble: Yes No
Stroke: Yes No
Thyroid Problems: Yes No
Tuberculosis: Yes No
Tumor / growth on head / neck: Yes No
Ulcer: Yes No
Epilepsy: Yes No
Fainting / Dizziness : Yes No
Headaches (Frequent): Yes No
Hepatitis: Yes No
Herpes: Yes No
Kidney Disease: Yes No
Liver Disease: Yes No
Nervous Problems: Yes No
Psychiatric Care: Yes No

List any other medical issues you have_____

List any serious Illnesses / surgeries / hospitalizations_____

List any medications you are taking_____

Pregnant **:** Yes No
Nursing : Yes No

Signature: _____ Date: _____