Victor Drabkin DDS

Medical History

Patient Name_____ **Medical Alert**_____

Have you been under the care of a medical doctor during the past two years? ❍ Yes ❍ No If yes, please explain: _____

Physician's Name: _____ Address: _____ Phone: _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ❍ Yes ❍ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No If yes, please explain: _____

Do you take or have taken Fosamax, or other bisphosphonates? ❍ Yes ❍ No If yes, please explain: _____

Do you use tobacco? ❍ Yes ❍ No If yes, please explain: _____

Do you use controlled substances? ❍ Yes ❍ No If yes, please explain: _____

Women: Are You

Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking Oral Contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

Allergies:

Are you allergic to any of the following: ❍ Acrylic ❍ Asprin ❍ Codeine ❍ Latex ❍ Local Anesthetics ❍ Metal ❍ Penicillin ❍ Other: _____

If yes, please explain: _____

Do you have, or have you had, any of the following:

AIDS/HIV Positive ❍ Yes ❍ No	Congenital Heart Disorder ❍ Yes ❍ No	Heart Trouble/Disease ❍ Yes ❍ No	Psychiatric Care ❍ Yes ❍ No
Alzheimer's Disease ❍ Yes ❍ No	Convulsions ❍ Yes ❍ No	Hemophilia ❍ Yes ❍ No	Radiation Treatments ❍ Yes ❍ No
Anaphylaxis ❍ Yes ❍ No	Diabetes ❍ Yes ❍ No	Hepatitis A ❍ Yes ❍ No	Recent Weight Loss ❍ Yes ❍ No
Angina ❍ Yes ❍ No	Drug Addiction ❍ Yes ❍ No	Hepatitis B or C ❍ Yes ❍ No	Renal Dialysis ❍ Yes ❍ No
Arthritis/Gout ❍ Yes ❍ No	Emphysema ❍ Yes ❍ No	Herpes ❍ Yes ❍ No	Rheumatic Fever ❍ Yes ❍ No
Artificial Heart Valve ❍ Yes ❍ No	Epilepsy or Seizures ❍ Yes ❍ No	High Blood Pressure ❍ Yes ❍ No	Sinus Trouble ❍ Yes ❍ No
Artificial Joint ❍ Yes ❍ No	Excessive Bleeding ❍ Yes ❍ No	Hypoglycemia ❍ Yes ❍ No	Stomach/Intestinal Disease ❍ Yes ❍ No
Asthma ❍ Yes ❍ No	Fainting Spells/Dizziness ❍ Yes ❍ No	Kidney Problems ❍ Yes ❍ No	Stroke ❍ Yes ❍ No
Blood Disease ❍ Yes ❍ No	Frequent Headaches ❍ Yes ❍ No	Leukemia ❍ Yes ❍ No	Tuberculosis ❍ Yes ❍ No
Blood Transfusion ❍ Yes ❍ No	Genital Herpes ❍ Yes ❍ No	Liver Disease ❍ Yes ❍ No	Tumors or Growths ❍ Yes ❍ No
Cancer ❍ Yes ❍ No	Glaucoma ❍ Yes ❍ No	Low Blood Pressure ❍ Yes ❍ No	Ulcers ❍ Yes ❍ No
Chemotherapy ❍ Yes ❍ No	Heart Attack/Failure ❍ Yes ❍ No	Lung Disease ❍ Yes ❍ No	Venereal Disease ❍ Yes ❍ No
Chest Pains ❍ Yes ❍ No	Heart Murmur ❍ Yes ❍ No	Mitral Valve Prolapse ❍ Yes ❍ No	
Cold Sores/Fever Blisters ❍ Yes ❍ No	Heart Pacemaker ❍ Yes ❍ No	Pain in Jaw Joints ❍ Yes ❍ No	

Do you have or have you had any disease, condition, or problem not listed?

Updates:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____

Dentist Signature _____ Date _____

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