NORMAN C. GUILLEN, D.M.D., PC

Dentistry

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ❑ Examination ❑ Emergency ❑ Consultation

MEDICAL HISTORY:

Please Circle

Medical doctor's name_____

Are you under a doctor's care now? Why?_____ YES NO

Have you been hospitalized in the past two years? Why?_____ YES NO

Are you taking any medications, pills or drugs? What?_____ YES NO

_____

Are you allergic to any medications, anesthetics or substances? What?_____ YES NO

_____

(women) Are you pregnant?_____ Nursing?_____ Taking birth control pills?_____

Please circle if you've had any of the following:

Heart Trouble	**Chest Pain**	**Emphysema**	**Pain in Jaw Joints**
Heart Murmur	**Shortness of Breath**	**Frequent Cough**	**Cortisone Medicine**
Rheumatic Fever	**Scarlet Fever**	**Lung disease**	**Glaucoma**
Artificial Joints/Hips	**Swelling Feet/Ankles/**	**Tuberculosis**	**Epilepsy or Seizures**
Mitral Valve Prolapse	**Hands**	**Liver Disease**	**Nervousness**
AIDS	**Fainting or Dizziness**	**Hepatitis A (infec.)**	**Hypoglycemia**
High Blood Pressure	**Stroke**	**Hepatitis B (serum)**	**Psychiatric Care**
Low Blood Pressure	**Diabetes**	**Yellow Jaundice**	**Drug Addiction**
Congenital Heart Lesion	**Excessive Thirst**	**Cancer**	**Blood Transfusion**
Artificial Heart Valve	**Kidney Trouble**	**Thyroid Disease**	**Hemophilia**
Heart Pacemaker	**Ulcers**	**Parathyroid Disease**	**Venereal Disease**
Heart Surgery	**Allergies**	**X-Ray or Cobalt**	**Cold Sores**
Blood Disease	**Asthma**	**Treatment**	**Fever Blisters**
Anemia	**Hay Fever**	**Chemotherapy/Radiation**	**Herpes**
Joint Replacement	**Sinus Trouble**	**Arthritis/Gout**	**Bruise Easily**
		Rheumatism	**Sickle Cell Anemia**

Have you ever had any other serious illness not listed above? YES NO

Please describe in detail_____

_____

Do you wish to talk to the doctor privately about any problems? YES NO

X_____ Date_____

Patient Signature (Parent or Guardian)

Reviewed by: Doctor_____ Date_____

MEDICAL UPDATES:

I have read my MEDICAL HISTORY dated_____ and confirm that it adequately states past and present conditions.

DATE	CHANGES	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ❑_____	_____	_____
_____	_____	None ❑_____	_____	_____