Nidal S. Elias, D.D.S., M.S.

MEDICAL HISTORY

NAME: _____
DATE OF BIRTH: **SEX: M F**

Welcome!

So that we may provide you with the best possible care, please complete <u>both</u> sides of this medical/dental history form. All information is completely confidential.

1. **Have you been under the care of a medical doctor during the past two years? ……..Yes No**
   If yes, please state reason_____
   Physician's Name_____ Telephone_____
   Address_____

2. **Have you taken any medications or drugs during the past two years? …… Yes No**

3. **Are you taking any medications, drugs or pills now? …… Yes No**

   If yes, please list name and dosage_____

   _____

4. **Are you aware of having an <u>allergic</u> or <u>adverse</u> reaction to any medication or substance? ...Yes No**
   If yes, please list_____

5. **Have you been a patient in the hospital during the past five years? …….Yes No**

6. **Please indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item:**

Heart (Surgery, Disease)……..… Yes No	**Ulcers…..……..…….. Yes No**	**Hepatitis A,B……...Yes No**
Chest Pain……..……Yes No	**Diabetes……..…Yes No**	**STD ……..Yes No**
Congenital Heart Defect……..…Yes No	**Thyroid Problems….Yes No**	**A.I.D.S……..……Yes No**
Heart Murmur……. Yes No	**Glaucoma……... Yes No**	**H.I.V. Positive……..…… Yes No**
Blood Pressure (H/L)…….……... Yes No	**Contact Lenses…… .Yes No**	**Cold Sores/Fever Blisters…...Yes No**
Mitral Valve Prolapse……..…Yes No	**Emphysema…….. Yes No**	**Blood Transfusion…….. Yes No**
Artificial Heart Valve……..…… Yes No	**Chronic Cough……..Yes No**	**Hemophilia…….…….. Yes No**
Heart Pacemaker……..…… Yes No	**Tuberculosis…….Yes No**	**Sickle Cell Disease…….…… Yes No**
Rheumatic Fever……... Yes No	**Asthma…….. Yes No**	**Bruise Easily……..…….. Yes No**
Arthritis/ Rheumatitis ……..…. Yes No	**Hay Fever……...Yes No**	**Liver Disease……..……..Yes No**
Cortisone Medicine……..…..…Yes No	**Latex Sensitivity……Yes No**	**Yellow Jaundice……..…Yes No**
Swollen Ankles…….…… Yes No	**Allergies/Hives……..Yes No**	**Neurological Disorders…….. Yes No**
Stroke……..…….. Yes No	**Sinus Trouble……Yes No**	**Epilepsy or Seizures…….…... Yes No**
Diet (Special/Restricted)……..…Yes No	**Radiation Therapy…Yes No**	**Fainting or Dizzy Spells……. Yes No**
Artificial Joints……..…Yes No	**Chemotherapy……..Yes No**	**Nervous/Anxious……..……Yes No**
Kidney Trouble……..……... Yes No	**Tumors/Cancer…….Yes No**	**Psychiatric Care……. Yes No**

7. **Do you have or have you had any disease, condition or problem not listed above? …… Yes No**
   If yes, please list: _____

8. **Have you lost or gained more than 10 pounds in the past year? …….Yes No**

9. **WOMEN:**
   Are you: Pregnant? Yes ___Months No___ Nursing? Yes No Taking Birth Control? Yes No

(PLEASE COMPLETE OTHER SIDE)

Patient/Guardian Signature _____Date_____