# 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_____**