Medical History **Dr. Araceli Silva Family Dentistry**

Name:_____ Date of Birth:_____m/_____d/_____yr

Current Address:_____ Phone #:_____

City:_____ Postal Code:_____ Cell Phone #:_____

Email Address:_____

Emergency Contact:_____ Phone #:_____

Medical Doctor:_____ Phone #:_____

Some medical conditions affect your dental health or the approach to dental treatment. Help us, Help you.

1) Have you ever had a serious/major illness? No( ) Yes ( ) please offer any detail:
_____

2) Have you been hospitalized in the last 2 years? No ( ) Yes ( )
reason:_____

3) Are you taking **ANY** medications at this time? No ( ) Yes ( ) please
list:_____

4) Do you take any of these medications daily? (please check) Aspirin( ) Coumadin ( ) Heparin ( ) Hormonal replacements ( )Oral Contraceptives ( ) None ( )

5) Do you have an allergy or sensitivity to any substance?
- A) Latex No ( ) yes ( )
- B) unusual reaction to local anesthesia(freezing) no ( ) yes ( )
  specify_____
- C) Negative drug reaction no ( ) yes ( ) name of
  drug(s)_____
- D) No allergies ( )
- E) Specify other allergies or
  reactions_____

6) **Females:** Are you pregnant? No ( ) Yes ( ) possibly ( )

7) **Please mark any illnesses or conditions you have experienced:**

( ) Alzheimer Disease	( ) Down Syndrome	( ) Joint Surgery-knee, hip replacement
( ) Angina	( ) Drug/alcohol addiction	( ) Kidney disease
( ) Arthritis	( ) Epilepsy, seizures	( ) Liver disease
( ) Asthma	( ) Fibromyalgia	( ) Lung disease, emphysema
( ) Autism	( ) Heart murmur (MVP)	( ) Osteoporosis
( ) high blood pressure	( ) Heart pacemaker	( ) Psychiatric disorder
( ) low blood pressure	( ) Heart surgery	( ) Rheumatic fever
( ) Cancer	( ) Hemophilia	( ) Stroke
( ) Cholesterol concern	( ) Hepatitis	( ) Sinus problems
( ) Diabetes	( ) HIV/AIDS	( ) Thyroid disorder

8) Please specify any other health concern you may have which is not listed above:
_____

9) Do you smoke no ( ) yes( ) amount per day_____number of years_____former smoker no ( ) yes ( )

10) I certify that the above information is correct and complete_____Signature-patient or guardian

Reviewed by:_____DDS_____Date