SOUTHERN SMILE STUDIO

MEDICAL HISTORY

- PHYSICIAN'S NAME _____ PHONE_____ ADDRESS_____
- DATE OF LAST PHYSICAL EXAMINATION _____
- ARE YOU IN GOOD HEALTH? _____ YES _____ NO
- ARE YOU UNDER THE CARE OF A PHYSICIAN? _____ YES _____ NO
- IF SO, FOR WHAT? _____
- ARE YOU TAKING ANY MEDICATION AT PRESENT? _____ YES _____ NO
- LIST ALL MEDICINE TAKING_____
- NAME OF PHARMACY _____ PHONE _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? CHECK THOSE THAT APPLY.
(ASK IF YOU HAVE A QUESTION, THIS IS VERY IMPORTANT!)

___ AIDS/HIV
___ ANEMIA
___ ARTHRITIS
___ ARTIFICIAL JOINTS
___ ASTHMA
___ BLOOD DISEASE
___ CANCER
___ COLD SORES/FEVER BLISTERS
___ CORTISONE MEDICATION
___ DIABETES
___ EMPHYSEMA
___ EPILEPSY/SEIZURES
___ EXCESSIVE BLEEDING
___ GLAUCOMA
___ HAY FEVER
___ HEAD INJURIES
___ HEART ATTACK
___ HEART DISEASE
___ HEART SURGERY
___ HEART MURMUR
___ HEPATITIS
___ HIGH BLOOD PRESSURE
___ JAUNDICE
___ KIDNEY DISEASE
___ LATEX ALLERGY
___ LIVER DISEASE
___ LOW BLOOD PRESSURE
___ MENTAL DISORDERS
___ MITRAL VALVE PROLAPSE
___ NERVOUS DISORDERS
___ PACEMAKER
___ RADIATION TREATMENT
___ RESPIRATORY PROBLEMS
___ RHEUMATIC FEVER
___ SINUS PROBLEMS
___ STOMACH PROBLEMS
___ STROKE
___ THYROID DISEASE
___ TUBERCULOSIS
___ TUMORS
___ ULCERS
___ VENEREAL DISEASE

OTHER:_____
_____
_____

- **ARE YOU ALLERGIC TO ANY MEDICATIONS? YES _____ NO _____**
- **PLEASE LIST ANY MEDICINES OR SUBSTANCES TO WHICH YOU ARE ALLERGIC:_____**

_____

- **DO YOU USE TOBACCO PRODUCTS?** _____
- **IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY?**

_____

ARE YOU OR DO YOU SUSPECT THAT YOU ARE PREGNANT? YES ____ NO____
ARE YOU TAKING BIRTH CONTROL PILLS? YES ____ NO____