

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

