

Medical History

LAST NAME	FIRST NAME	MID. INITIAL	DATE
MAILING ADDRESS	CITY	STATE	ZIP CODE
			GENDER Male Female
PHONE NUMBERS			EMAIL ADDRESS
H:	W:	Cell:	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	STATUS Married Divorced Widowed Single Child	

If you experience symptoms or have a condition you are being treated for medically, *please circle all that apply.*

Heart Conditions/Chest pain Congenital Heart Lesions Circulatory Problems Artificial Heart Valve Heart Pacemaker Artificial Joints Cortisone Treatments High Blood Pressure Low Blood Pressure Stroke Kidney Disease Ulcers Diabetes Hypoglycemia Thyroid Problems	Eye Surgery Glaucoma Contact Lenses Emphysema Asthma/Breathing problems Cough (bloody or persistent) Tuberculosis Weight Loss, unexplained Radiation /Chemotherapy Cancer/ Tumors Liver Disease Hepatitis /Type: _____ Jaundice	Blood Disease Bleeding Abnormally AIDS/HIV Anemia Arthritis Back Problems Nervous Problems/Anxiety Hyperactive Epilepsy STD'S Drug/Alcohol Dependent Herbal + Dietary Supplement Splenectomy Pregnant Swollen Neck	Glands Headaches Jaw Pain Dry mouth Tonsillitis GAGS Easily Hearing Impaired Psychiatric Care Tobacco products High Cholesterol Dizziness if reclined Other: _____ _____ _____
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Do you have any ALLERGIES? (Please circle all that apply): ASA Codeine Demerol Latex
 Metal Penicillin Sulfa Tetracycline Local Anesthesia Other: _____

Have you ever had any complications following dental treatment?	YES	NO
Have you been admitted to the hospital or needed emergency care in the past two years?	YES	NO
Are you under regular medical care from a physician for a condition?	YES	NO
Have you ever been a victim of abuse?	YES	NO
Do you have a prosthetic cardiac valve?	YES	NO
Have you had previous bouts of infective endocarditis?	YES	NO
Do you have any congenital heart diseases?	YES	NO
Are you a cardiac transplant recipient who developed valvulitis?	YES	NO

To the best of my knowledge, all of the preceding information provided is true and correct. If I have any change in my health, I will inform the doctors at the next appointment without fail. I am also aware that Evergreen Dental Associates participates with the HIPAA privacy act, ensuring me that they take all reasonable precautions, making sure my personal information remains private.

SIGNATURE/ RELATIONSHIP



EVERGREEN DENTAL ASSOCIATES, LLC

281 Western Avenue • Augusta • Maine • 04330 • (207) 622-0861

Name: _____

Date: _____

Please list any medications that you are currently taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Have you in the past or are you currently taking any of the following?
(Circle those that apply and mark past or present):**

Amoxicillin as a Pre-Med

Other as a Pre-Med

Erythromycin as a Pre-Med

MAO Inhibitors

Birth Control Pills

**Anticoagulants
(aspirin, heparin, Coumadin)**

Bisphosphorites (oral or IV)