Fox Dentistry

MEDICAL HISTORY
(PLEASE PRINT OR TYPE)

Guy L. Fox, D.D.S.
Amy L. Fox, D.D.S.

Patient Name_____

Are you having any pain or discomfort at this time? ☐ Yes ☐ No Explain:_____

Has there been any change in your general health within the last year? ☐ Yes ☐ No Explain:_____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

Y	N		Y	N		Y	N	
☐	☐	Heart Pacemaker	☐	☐	Chronic Diarrhea	☐	☐	Anemia
☐	☐	Heart Problems	☐	☐	Hearing Disorder	☐	☐	Visual Disorder
☐	☐	Heart Murmur	☐	☐	Allergies to Anesthetics	☐	☐	Use Tobacco Products
☐	☐	Mitral Valve Prolapse	☐	☐	Allergies to Medicine or Drugs	☐	☐	Tuberculosis
☐	☐	High Blood Pressure	☐	☐	General Allergies	☐	☐	Fainting Spells/Dizziness
☐	☐	Low Blood Pressure	☐	☐	Blood Disease	☐	☐	Thyroid Problems
☐	☐	Circulatory Problems	☐	☐	Arthritis	☐	☐	Hives or Skin Rash
☐	☐	Nervous Problems	☐	☐	Special-Diet	☐	☐	Use Recreational Drugs
☐	☐	Radiation Treatment/Chemotherapy	☐	☐	Swollen Neck Glands	☐	☐	Cold Sores
☐	☐	Artifical Heart Valves	☐	☐	Rheumatic Fever	☐	☐	Chest Pains
☐	☐	Artificial Hip/Knee Joints	☐	☐	Rheumatic Heart Disease	☐	☐	Swelling of Feet/Ankles/Hands
☐	☐	Recent Weight Loss	☐	☐	Sinus Problems	☐	☐	Excessive Thirst
☐	☐	Back Problems	☐	☐	"A.I.D.S"	☐	☐	Alcoholism
☐	☐	Diabetes	☐	☐	Immunosuppressive Disorders			
☐	☐	Respiratory Disease/Lung Disease	☐	☐	Stroke			
☐	☐	Asthma	☐	☐	Ulcer			
☐	☐	Epilepsy	☐	☐	Venereal Disease			
☐	☐	Headaches	☐	☐	Chemical/Drug Dependency			
☐	☐	Hepatitis, Jaundice or Liver Disease	☐	☐	Hemophilia			
☐	☐	Cancer	☐	☐	Blood Transfusion			
☐	☐	Psychiatric Care	☐	☐	Bruise Easily			

Do you have any disease or condition not listed?
☐ Yes ☐ No. If yes, describe:

Pharmacy Name:

Phone # :

ARE YOU TAKING ANY MEDICATIONS AT THIS TIME? ☐ Yes ☐ No. If Yes, please list

MEDICATION	DOSAGE	FREQUENCY	FOR WHAT CONDITION	STARTED WHEN?

DO YOU HAVE ANY ALLERGY OR HAVE YOU EVER HAD AN ADVERSE REACTION TO:
☐ Penicillin ☐ Erythromycin ☐ Aspirin ☐ Ibuprofen ☐ Tetracycline ☐ Codeine
☐ Dental Anesthetics ☐ Sulfa Drugs ☐ Latex ☐ Iodine ☐ Nickel, other metals
☐ Other_____

Have you ever taken the drug Phen-fen?
☐ Yes ☐ No

Have you ever taken pre-medication prior to dental treatment? ☐ Yes ☐ No

ARE YOU UNDER THE CARE OF A PHYSICIAN? ☐ Yes ☐ No. If Yes, for what conditions?

Name of Physician_____ Phone Number_____ Fax Number_____

Date of Last Physical_____ If patient is a child, what is his/her weight?_____

Name of Previous Dentist_____ Phone Number_____

FOR WOMEN ONLY: Do suspect that you are pregnant? ☐ Yes ☐ No. If yes, what month_____

Are you nursing? ☐ Yes ☐ No. Are you taking birth control pills? ☐ Yes ☐ No.