Dental Smiles of West Loop

1202 W Madison Street, Chicago,IL,60607 312-724-7161

# MEDICAL HISTORY

Physician_____Date of Last Visit_____

Address_____Phone #_____

Please circle Yes or No ( If yes, please explain)

1.Are you taking any medication including vitamins? Yes No _____

2. Are you allergic to medication,dyes, foods ? Yes No _____

3. Do you have history of a major illness? Yes No _____

4. Have you had any surgeries? Yes No _____

5. Have you been involved in any serious accidents? Yes No _____

6. Have you seen a physician in the last 12 months? Yes No _____

7. Females only: Are you pregnant ? If yes, how many months? _____

Circle any medical conditions below that you have had or currently have:

| | | | |
|---|---|---|---|
| Abnormal bleeding/Hemophilia | Dizziness | Herpes | Prolonged Bleeding |
| Anemia | Epilepsy | High Blood Pressure | Radiation Therapy |
| Arthritis | Gastrointestinal Disorders | HIV/AIDS | Chemotherapy |
| Asthma or Hay fever | Heart Murmur | Kidney Problems | Rheumatic Fever |
| Bone disorder | Heart Problems | Nervous Disorders | Tuberculosis |
| Diabetes | Hepatitis | Pneumonia | Cancer/Tumors |

Are there any conditions not listed above that you feel we should be aware of?

_____

Patient Signature ( parent, if minor) _____Dr.Signature_____

Date: _____Date_____

Print Name:_____