

# Because its your Smile. Marcus Whitmore, DDS

## Your Health.

Name \_\_\_\_\_

Have you been under the care of a medical doctor during the past two years? Y N

If Yes, what for? \_\_\_\_\_

Physicians name \_\_\_\_\_ Phone \_\_\_\_\_

Location/Address \_\_\_\_\_

Have you taken any medications or drugs during the past two years? Y N

Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? Y N

If yes, please list name and dosage \_\_\_\_\_

Are you aware of having any allergic or adverse reactions to any medication or substance? Y N

If yes, please list \_\_\_\_\_

Have you been a patient in the hospital during the past five years? Y N

Have you lost or gained more than 10 pounds in the past year? Y N

Do you have or have you had any disease, condition, or problem not listed? Y N

If yes, please list \_\_\_\_\_

Do you take a bone-building drug such as Fosamax, Actonel, Zometa, or Pamidronate? Y N

If so, orally or IV? (circle one)

Do you currently use tobacco? Y N

If so, how long? \_\_\_\_\_ Do you want to quit? Y N

Indicate which of the following you have had or have at present:

Heart (Surgery, Disease, Attack)	Y N	Tuberculosis	Y N
Congenital Heart Disease	Y N	Asthma	Y N
High Blood Pressure	Y N	Latex Sensitivity	Y N
Artificial Heart Valve	Y N	Allergies/Sinus Trouble	Y N
Heart Pacemaker	Y N	Radiation/Chemotherapy	Y N
Arthritis/ Rheumatism	Y N	Tumors	Y N
Cortisone Medicine	Y N	Hepatitis A B C	Y N
Swollen Ankles	Y N	Venereal Disease / AIDS / HIV	Y N
Stroke	Y N	Cold Sores/Fever Blisters	Y N
Diet (Special/Restricted)	Y N	Blood Transfusion	Y N
Artificial Joints (hip, knee, etc)	Y N	Bruise Easily	Y N
Kidney Trouble	Y N	Liver Disease / Yellow Jaundice	Y N
Diabetes	Y N	Neurological Disorders	Y N
Thyroid Problems	Y N	Epilepsy or Seizures	Y N
Glaucoma	Y N	Nervous / Anxiety	Y N
Emphysema	Y N	Psychiatric/ Psychological Care	Y N

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Name \_\_\_\_\_

## Your Health; Continued

### SLEEP HABITS

- Do you use more than two pillows to sleep?      Y N  
Do you have any trouble sleeping?                Y N  
Do you snore, or have you been told that you do?    Y N  
Do you awaken with jaw or head pain?            Y N

### WOMEN

- Are you pregnant or think you may be pregnant?    Y N  
Are you nursing?                                            Y N  
Do you use birth control medication?                Y N    Type: \_\_\_\_\_

I understand that to the best of my knowledge, the questions on this form have been accurately answered. I have documented my medical history and confirm it states past and present conditions. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any medical status or condition. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I authorize Whitmore Dental to perform all necessary dental procedures that I may need with my informed consent. I also give permission to Whitmore Dental to use any photos that may be taken used for lecturing, publishing, marketing, and educational purposes.

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Dr. Marcus Whitmore's Review

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_