NORTHSIDE DENTAL

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Your Primary Physician's Name & Phone Number: _____

Conditions	Conditions	Conditions
Y N Heart Murmur	Y N Liver Disease	Y N Artificial Heart Valve
Y N Venereal Disease/STD's	Y N Kidney Problems	Y N Artificial Bones/Joints
Y N Ulcers	Y N HIV+/AIDS	Y N Arthritis
Y N Tuberculosis	Y N High Blood Pressure	Y N Angina Pectoris
Y N Thyroid Problems	Y N Hepatitis B	Y N Anemia
Y N Stroke	Y N Hepatitis A	Y N Allergies
Y N Sinus Problems	Y N Hepatitis C	Y N Frequent Headaches
Y N Hemophilia	Y N Abnormal Bleeding	Y N Cancer-Chemotherapy
Y N Heart Attack/Date: _____ ____	Y N Reflux	Y N Blood Transfusion
Y N Shingles	Y N Hay Fever	Y N Asthma
Y N Seizures	Y N Sleep apnea/Snoring	Y N Fainting Spells
Y N Rheumatic Fever	Y N Used a CPAP	Y N Drug Abuse
Y N Radiation Therapy	Y N Cold Sores/Fever Blisters	Y N Low Blood Pressure
Y N Colitis	Y N Psychiatric Problems	Y N Diabetes
Y N Pace Maker	Y N Emphysema	Y N Congenital Heart Defect
Y N Mitral Valve Prolapse	Y N Difficulty Breathing	Y N Pre-Med

Do you smoke or use tobacco: Yes ○ No ○

Have you ever used the drug "Fen-Phen"? Yes ○ No ○

*Any other condition(s) not listed, please describe here: _____
_____

Allergies:

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Sulfa
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Tetracycline
Other: _____

Females Only:

Y N Are you taking birth control pills?
Y N Are you nursing?
Y N Are you pregnant?
# of weeks _____

Please list any medications you are currently taking: _____
_____

I request and authorize Dr. Metwally and/or his associate and assistants to examine, clean and provide my/the patient's dental treatment as necessary. I further request and authorize the taking of dental x-rays/photographs as may be considered necessary for diagnostic or educational purposes. **I understand that this office only uses composite (tooth-colored) filling material to restore teeth and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.**

Signature: _____ Date: _____