MICHAEL S. PUGH, D.M.D.
Dentistry

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: ❑ Examination ❑ Emergency ❑ Consultation

MEDICAL HISTORY:

Please Circle

Medical doctor's name_____

Are you under a doctor's care now? Why?_____ YES NO

Have you been hospitalized in the past two years? Why?_____ YES NO

Are you taking any medications, pills or drugs? What?_____ YES NO

_____

Are you allergic to any medications, anesthetics or substances? What?_____ YES NO

_____

(women) Are you pregnant?_____ Nursing?_____ Taking birth control pills?_____

Please <u>circle</u> if you've had any of the following:

Heart Trouble
Heart Murmur
Rheumatic Fever
Artificial Joints/Hips
Mitral Valve Prolapse
AIDS
High Blood Pressure
Low Blood Pressure
Congenital Heart Lesion
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Blood Disease
Anemia
Joint Replacement

Chest Pain
Shortness of Breath
Scarlet Fever
Swelling Feet/Ankles/ Hands
Fainting or Dizziness
Stroke
Diabetes
Excessive Thirst
Kidney Trouble
Ulcers
Allergies
Asthma
Hay Fever
Sinus Trouble

Emphysema
Frequent Cough
Lung disease
Tuberculosis
Liver Disease
Hepatitis A (infec.)
Hepatitis B (serum)
Yellow Jaundice
Cancer
Thyroid Disease
Parathyroid Disease
X-Ray or Cobalt Treatment
Chemotherapy/Radiation
Arthritis/Gout
Rheumatism

Pain in Jaw Joints
Cortisone Medicine
Glaucoma
Epilepsy or Seizures
Nervousness
Hypoglycemia
Psychiatric Care
Drug Addiction
Blood Transfusion
Hemophilia
Venereal Disease
Cold Sores
Fever Blisters
Herpes
Bruise Easily
Sickle Cell Anemia

Have you ever had any other serious illness not listed above? YES NO

Please describe in detail_____

_____

Do you wish to talk to the doctor privately about any problems? YES NO

X_____ Date_____

Patient Signature (Parent or Guardian)

Reviewed by: Doctor_____ Date_____

MEDICAL UPDATES:

I have read my MEDICAL HISTORY dated_____ and confirm that it adequately states past and present conditions.

DATE	CHANGES	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ❑_____	___	_____
_____	_____	None ❑_____	___	_____