Hugh D. Burke Jr., D.D.S. Inc.

Patient Medical History

Patient's Name _____ Date of Birth _____
Last First Initial

If Child: Parent's Name _____

Are you under a physician's care? …….. YES NO

Since when? _____ Why? _____

Physician's Name, tel. _____

When was your last complete physical exam? _____

Are you taking any medication or substances? ……. YES NO
(If yes, please list medications in comments section.)
Are you allergic to any medications or substances? (please list) ……. YES NO
Do you have any other allergies or hives? …… YES NO
Do you have any problems with penicillin, antibiotics, anesthetics
or other medications? …… YES NO
Are you sensitive to any metals or latex? …….. YES NO
Are you pregnant or suspect you may be? ……. YES NO
Do you use any birth control medications? ……. YES NO
Have you ever been treated for or been told you might have heart disease? ….. YES NO
Do you have a pacemaker, an artificial heart valve implant, or been
diagnosed with mitral valve prolapse? ……. YES NO
Have you ever had rheumatic fever? …….. YES NO
Are you aware of any heart murmurs? …….. YES NO
Do you have high or low blood pressure? (please circle) …….. YES NO
Have you ever had a serious illness or major surgery? …….. YES NO
If so, explain _____
Have you ever had radiation treatment, chemo treatment for tumor,
growth or other condition? …… YES NO
Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
Do you have any artificial joints/prosthesis? …… YES NO
Do you have any blood disorders, such as anemia, leukemia, etc? ……. YES NO
Have you ever bled excessively after being cut or injured? …… YES NO
Do you have any stomach, kidney, liver problems? (please circle) …… YES NO
Are you diabetic? …….. YES NO
Do you have fainting or dizzy spells? …….. YES NO
Do you have asthma? …… YES NO
Do you have epilepsy or seizure disorders? ……. YES NO
Do you or have you had venereal disease? …….. YES NO
Have you tested HIV positive? …… YES NO
Do you have AIDS? …… YES NO
Have you had or do you test positive for hepatitis? …… YES NO
Do you or have you had T.B.? …… YES NO
Do you smoke, chew, use snuff or any other forms of tobacco? …… YES NO
Do you regularly consume more than one or two alcoholic beverages a day? … YES NO
Do you habitually use controlled substances? …….. YES NO
Have you had psychiatric treatment? …… YES NO
Do you have any disease condition, or problem not listed? If so, explain _____

COMMENTS

Is there anything else we should know about your health that we have not covered in this from? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

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