Joyful Smile Family Dentistry
Jeuel "Joy" D. Española, D.M.D.

Medical History

Your current physical health is: Good ◯ Fair ◯ Poor ◯

Are you currently under the care of a physician? Yes ◯ No ◯

Physician Name: ______________________________ Physician Phone Number: ______________________________

Have you had surgeries or been hospitalized with in the last two years

If yes, please explain: ____

Are you taking any prescription/over the counter drugs? Yes ◯ No ◯

If yes, please list:

____

-Do you use or smoke tobacco in any form? Yes No -Have you or do you take Redux/Fen Phen or Pondimin? Yes No

-Have you or are you currently taking Bisphosphonates (ex: Fosamax, Boniva, Reclast)? Yes No

***For Women: Please Circle One**

*Are you taking birth control pills? Yes / No *Are you pregnant? Yes / No

*Week # ______________ *Are you nursing? Yes / No

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	◯ YES	◯ NO	Epilepsy	◯ YES	◯ NO	Liver Disease/ HEP / Jaundice/ Cirrhosis	◯ YES	◯ NO
Alcohol/Drug Abuse	◯ YES	◯ NO	Fainting Spells	◯ YES	◯ NO	Lung Disease	◯ YES	◯ NO
Alzheimer's Disease	◯ YES	◯ NO	Frequent Headaches	◯ YES	◯ NO	Mental Health Disorder	◯ YES	◯ NO
Asthma/Emphysema	◯ YES	◯ NO	Glaucoma	◯ YES	◯ NO	MRSA	◯ YES	◯ NO
Artificial Bones/Joints/Valves	◯ YES	◯ NO	Heart Attack/Angina Pectoris	◯ YES	◯ NO	Organ Transplant	◯ YES	◯ NO
Arthritis/Gout	◯ YES	◯ NO	Heart Disease/Congenital	◯ YES	◯ NO	Osteoporosis/Osteopenia	◯ YES	◯ NO
Blood Disease/Anemia	◯ YES	◯ NO	Heart Murmur/Mitral Valve	◯ YES	◯ NO	Pacemaker	◯ YES	◯ NO
Blood Disease/Transfusions	◯ YES	◯ NO	Heart Surgery	◯ YES	◯ NO	Rheumatic/Scarlet Fever	◯ YES	◯ NO
Cancer/Chemo/Radiation	◯ YES	◯ NO	Herpes/Fever Blisters	◯ YES	◯ NO	Sinus Problems	◯ YES	◯ NO
Chronic Cough	◯ YES	◯ NO	High/Low Blood Pressure	◯ YES	◯ NO	Thyroid Problems	◯ YES	◯ NO
Colitis	◯ YES	◯ NO	High Cholesterol	◯ YES	◯ NO	Tuberculosis	◯ YES	◯ NO
Diabetes	◯ YES	◯ NO	HIV	◯ YES	◯ NO	Ulcers	◯ YES	◯ NO
Eating Disorder	◯ YES	◯ NO	Kidney Problems	◯ YES	◯ NO	Venereal Disease	◯ YES	◯ NO

Are you allergic to any of the following items?

Aspirin/NSAIDS:	◯ YES	◯ NO	Latex:	◯ YES	◯ NO	Epinephrine:	◯ YES	◯ NO	Sulfa:	◯ YES	◯ NO
Penicillin/Amoxicillin:	◯ YES	◯ NO	Codeine:	◯ YES	◯ NO	Tetracycline:	◯ YES	◯ NO	OTHER:	◯ YES	◯ NO

Please list any other drugs that you are allergic to: ____

Please list any other conditions, diseases, or problems not listed above (ex: Autism, ADD/ADHD etc.):

____

Patient Signature: ______________________________ Date: ______________________________

Doctor Signature: ______________________________ Date: ______________________________