Tony T. Athans D.D.S.
MODERN DENTAL INNOVATIONS
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MEDICAL INFORMATION HISTORY

CIRCLE THE APPROPRIATE ANSWER. YOUR ANSWERS WILL BE CONFIDENTIAL.

Yes No Are you taking any blood thinners? If yes, what?_____
Yes No Are you taking any medication, drugs or pills? If yes, what?_____
Yes No Are you presently in good health?
Yes No Have you been under a physician's care in the last 2 years?
Last Medical Exam_____Name of Physician_____

ARE YOU ALLERGIC TO OR TOLD NOT TO TAKE:

Yes No Penicillin
Yes No Codeine
Yes No Others (Please Specify)_____

HAVE YOU EVER BEEN TREATED FOR OR DO YOU HAVE:

Yes No Heart disease
Yes No Rheumatic fever
Yes No High blood pressure
Yes No Shortness of breath
Yes No Pain, pressure in chest
Yes No Anemia
Yes No Excessive bleeding
Yes No Heart murmur
Yes No Mitral Valve Prolapse
Yes No Artificial heart valves
Yes No Stroke
Yes No Jaundice
Yes No Hepatitis
Yes No Glaucoma
Yes No Ulcers
Yes No A.I.D.S.
Yes No Herpes
Yes No Prosthetic Joints (i.e. knee, hip etc.)
Yes No Do you have any other condition/disease that we should know about?
Yes No May we contact you physician regarding your medical history?

Yes No Tuberculosis or lung disease
Yes No Asthma or hay fever
Yes No Allergies (including jewelry)
Yes No Persistant cough
Yes No Epilepsy
Yes No Fainting spells
Yes No Sinus trouble
Yes No Nervous problems
Yes No Cancer
Yes No Arthritis
Yes No Diabetes
Yes No Ear problems
Yes No Recent Surgery
If yes, what?_____

FOR WOMEN:
Yes No Are you pregnant?
Due date?_____
Yes No Are you on birth control pills?

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

_____ Patient Signature

_____ Date