Steven C. Wilburn D.M.D.
Kyle B. Wilburn D.D.S.

MEDICAL HISTORY

Today's Date: _____

PATIENT NAME:_____

Medical ID # _____

DOB: _____

Physician's Name_____

Your current health is? (Circle) Good Fair Poor

Are you currently under the care of a physician for a health condition? Yes No If yes, for what condition?

Are you allergic to or had a bad reaction to any of the following: (Circle Y or N)

Y	**N**	**Penicillin**	**Y**	**N**	**Tetracycline**
Y	**N**	**Erythromycin**	**Y**	**N**	**Sulfa**
Y	**N**	**Aspirin**	**Y**	**N**	**Latex**
Y	**N**	**Metals**	**Y**	**N**	**Dental Anesthetics**

Have you had a bad reaction to any other medicine or materials? Y N If yes, please list

_____

_____

Please list all prescriptions you are taking: _____

_____

Please list all over-the-counter medications or "Supplements" you are taking: _____

_____

Have you had artificial joint replacement(s): Y ___ N ___ Date of Procedure(s):_____

Have you experienced any of the following diseases or medical problems (circle Yes or No):

Y	**N**	**High Blood Pressure**	**Y**	**N**	**Epilepsy or seizures**	**Y**	**N**	**Cancer or Tumors**
Y	**N**	**Abnormal Bleeding**	**Y**	**N**	**Emphysema**	**Y**	**N**	**Kidney problems**
Y	**N**	**Stroke**	**Y**	**N**	**Tuberculosis**	**Y**	**N**	**Venereal disease or STD's**
Y	**N**	**Heart attack**	**Y**	**N**	**Persistent cough**	**Y**	**N**	**HIV+/ AIDS**
Y	**N**	**Heart Surgery**	**Y**	**N**	**Diabetes**	**Y**	**N**	**Chemo or radiation treatment**
Y	**N**	**Low Blood Pressure**	**Y**	**N**	**Fainting spells**	**Y**	**N**	**Drug or alcohol abuse**
Y	**N**	**Heart Valve replacement**	**Y**	**N**	**Frequent or severe headaches**	**Y**	**N**	**Herpes or Cold sores**
Y	**N**	**Atrial Fibrillation**	**Y**	**N**	**Hepatitis or liver disease**	**Y**	**N**	**Steroid Therapy**
Y	**N**	**Pacemaker**	**Y**	**N**	**Glaucoma**	**Y**	**N**	**Thyroid issues**
Y	**N**	**Asthma**	**Y**	**N**	**Arthritis**	**Y**	**N**	**Psychiatric episodes**
Y	**N**	**Anemia**	**Y**	**N**	**Colitis or Ulcers**			

Medical History (pg. 2)

Are you now taking, or have you ever taken any medications to strengthen your bones or increase your bone density? Please circle: Y N

If yes, what medication? _____

Have you ever been told that you should take antibiotics prior to dental work or dental cleanings? Y N

If yes, why? _____

Do you smoke or use tobacco in any form? Y N

Please list any serious medical condition(s) that you have experienced: _____

_____

_____

Women Only:

Are you pregnant? Y N Unsure If yes, how far along are you (months)? _____

Are you nursing ? Y N Are you taking birth control medication? Y N

Dental History:

Why have you come in today? _____

How would you describe your current dental health? _____

_____

Are you happy with your smile, and if not, what would you change? _____

_____

Previous dentist's name_____ Approx. date of last visit: _____

I affirm that the information I have given on this form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical/health status.

Signature: _____ Date: _____

Office Notes: _____

_____