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www.salinadentist.com

Patient's Name:					
Address:		Today's Date	Date of Last Visit:	Date of Med History	
City State Zip:			Email		
Home Phone:	Work Phone:	Birth Date	Soc Sec #:	Marital Status	
Primary Dental Guarantor:					
Secondary Dental Guarantor:		Home Phone:	Work Phone:		
Physician Name:		Physicians Phone:			
Pharmacy:		Pharmacy Phone:			
Medical Alerts:					

If female please answer the following:

Please answer the following:

Y N	Are you taking Birth Control Pills	Do you smoke or use tobacco?	Height:
Y N	Are you Pregnant? If yes # of weeks	Y N	
Y N	Are You Nursing?	BP	Heart Rate
			Weight:

Conditions:

		<u>CONDITIONS</u>			<u>CONDITIONS</u>			<u>CONDITIONS</u>
Y	N	Heart Attack	Y	N	Blood Transfusion	Y	N	Shingles
Y	N	Heart Murmur	Y	N	Hemophilia	Y	N	Tuberculosis
Y	N	Mitral Valve Prolapse	Y	N	Sickle Cell Disease	Y	N	HIV
Y	N	Heart Disease or Defect	Y	N	Cancer-Chemotherapy			Positive/AIDs
Y	N	Heart Surgery	Y	N	Radiation Therapy	Y	N	Venereal Disease
Y	N	Rheumatic Fever	Y	N	Colitis			Alcohol Abuse
Y	N	Artificial Heart Valve	Y	N	Ulcers	Y	N	Drug Abuse
Y	N	Angina or Chest Pain	Y	N	Diabetes			
Y	N	Pace Maker	Y	N	Kidney Problems			
Y	N	High Blood Pressure	Y	N	Thyroid Problems			
Y	N	Low Blood Pressure	Y	N	Glaucoma			
Y	N	Joint Replace- hip etc.	Y	N	Liver Disease	Y	N	<u>ALLERGIES:</u>
Y	N	Arthritis/Rheumatism	Y	N	Hepatitis A,B,C or other	Y	N	Aspirin
Y	N	Cortisone Medicine/steroids	Y	N	Yellow Jaundice	Y	N	Codeine
Y	N	Surgery/Hospitalization	Y	N	Fainting or Dizzy Spells	Y	N	Dental Anesthetics
Y	N	Allergies or Hives	Y	N	Nervous/Anxious			Erythromycin
Y	N	Asthma/Difficulty Breath	Y	N	Psychiatric Care	Y	N	Jewelry
Y	N	Emphysema	Y	N	Epilepsy or Seizures	Y	N	Latex
Y	N	Hay Fever	Y	N	Stroke	Y	N	Metals
Y	N	Sinus Problems	Y	N	Frequent Headaches	Y	N	Penicillin
Y	N	Abnormal Bleeding	Y	N	Fever Blister/Cold Sores	Y	N	Tetracycline
Y	N	Anemia				Y	N	Other:

Medications or Drugs:		
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Y N Do you have other conditions/problems not covered above?
If yes, please describe below....

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Notes: if you answered yes

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