Barry C. Reynolds, DMD

Patient Health History

NAME: ____
Last First Middle Initial

CURRENT MEDICATIONS:____

____

DATE OF LAST MEDICAL EXAM / PHYSICIAN'S NAME:__________________________

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?: (PLEASE CIRCLE EACH RESPONSE)

Abnormal Blood Pressure	**YES / NO**
Abnormal Heart Condition	**YES / NO**
Anemia	**YES / NO**
Arthritis	**YES / NO**
Asthma/Respiratory Problems	**YES / NO**
Cancer	**YES/ NO**
Currently Taking Blood Thinners	**YES / NO**
Diabetes	**YES / NO**
Epilepsy	**YES / NO**
Heart Attack/Stroke	**YES / NO**
Hepatitis A, B, or C	**YES / NO**
Heart Murmur	**YES / NO**
Herpes	**YES / NO**
Joint Replacement	**YES / NO**
Latex Allergy	**YES / NO**
Mitral Valve Prolapse	**YES / NO**
Pins, Plates or Screws Implanted	**YES / NO**
Currently Pregnant or Nursing	**YES / NO**
Rheumatic Fever	**YES/ NO**
Sinus Problems	**YES / NO**
Thyroid Therapy	**YES / NO**
Tuberculosis	**YES / NO**

HAVE YOU EVER BEEN REQUIRED TO PREMEDICATE WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT OTHER THAN FOR A TOOTHACHE? YES / NO

HAVE YOU EVER TESTED POSITIVE FOR AIDS / HIV? YES / NO

DO YOU HAVE ANY KNOWN DRUG ALLERGIES? YES / NO
IF SO, PLEASE EXPLAIN____

DO YOU CURRENTLY USE ANY ILLEGAL/STREET DRUGS? YES / NO

To the best of my knowledge all of the preceding answers are true and correct. If any future changes in my health occur, I will inform Dr. Reynolds and staff at the next appointment without fail.

Signature________________________________ Date__________ Reviewed by:________