D. Shane McPherson, DDS

Patient Name: _____

MEDICAL HISTORY

1. General Health (please check): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
2. Name and address of physician: _____
3. Last complete physical: _____
4. Has there been any change in your general health within the past year?.....YES NO
5. Are you now under the care of a physician?..... .....YES NO
   If so, what is the condition being treated? _____
6. Have you had any serious illness or operation in the past 5 years?.....YES NO
   If so, what was the illness or operation? _____
7. Have you been hospitalized for any serious illness within the past five (5) years?.....YES NO
   If so, what was the problem? _____
8. Do you use tobacco?.....YES NO
   If so, what type and what is your average daily usage? _____
9. Have you had any serious trouble associated with any previous dental treatment?.....YES NO
   If so, explain _____

Do you have or have you had any of the following diseases or problems? (Check all that apply)

☐ Damaged Heart Valve	☐ Cardiac Pacemaker	☐ Fainting Spells Or Seizures	☐ Fever Blisters
☐ Artificial Heart Valve	☐ Low Blood Pressure	☐ Diabetes	☐ Abnormal Or Prolonged
☐ Heart Murmur	☐ Stomach Ulcers	☐ Arthritis	Bleeding
☐ Mitral Valve Prolapse	☐ Hepatitis	☐ Inflammatory Rheumatism	☐ Anemia
☐ Congenital Heart Lesion	☐ Jaundice Or Liver Disease	☐ Hip Or Knee Replacement	☐ Cancer Or Tumor
☐ Cardiovascular Disease	☐ Kidney Problem	☐ AIDS Or HIV Positive Test	☐ Head and Neck Radiation in
☐ Heart Attack	☐ Allergies	☐ Tuberculosis	the Past 3 Years
☐ Angina	☐ Sinus Problem	☐ Persistent Cough	☐ Systemic Steroid Treatment
☐ Coronary Artery Disease	☐ Asthma	☐ Sexually Transmitted	
☐ High Blood Pressure	☐ Hayfever	Disease	
☐ Stroke	☐ Hives Or Skin Rash	☐ Herpes	

Women:

1. Are you pregnant?..... YES NO
2. Are you nursing?.....YES NO
3. Are you taking oral contraceptives?.....YES NO

Please list any MEDICATIONS, including over the counter drugs, you currently take:

Medication	Dosage	For what purpose?	Medication	Dosage	For what purpose?

Please list any MEDICATION ALLERGIES and REACTIONS you have had:

Medication	Reaction	Medication	Reaction

Do you have any disease, condition, or problem not listed above that you think I should know about.....YES NO
If so, explain _____

To the best of my knowledge the above questions have been accurately answered.

PATIENT NAME (print)_____ PATIENT SIGNATURE_____

DOCTOR'S NOTES

DATE / /

DOCTOR SIGNATURE_____