

Dr. Killian Patient Medical History (Copy)

Patient Name:

Birth Date:

Date Created:

Medical Doctor

Physician's Name

Address

Phone Number

When was your last complete physical exam?

Are you under your physician's care for any thing other than routine care?

Yes No

If yes

Health History

Are you taking any medication or substances?

Yes No

If yes

Are you taking a blood thinner?

Yes No

If yes

Do you routinely take health related Vitamins, Herbal / Natural supplements?

Yes No

If yes

Have you ever had a serious illness or majory surgery?

Yes No

If yes

Women - Are you Pregnant? How far along are you?

Yes No

If yes

Women- Do you use any birth control medication?

Yes No

If yes

Have you taken Fosamax, Zometa, Aredia (bisphosphonates) ?

Yes No

If yes

Do you have a form of Arthritis?

Yes No

If yes

Do you smoke, use snuff, or other forms of tobacco?

Yes No

If yes

Do you consume more than one or two alcoholic beverages a day?

Yes No

If yes

Do you habitually use controlled substances?

Yes No

If yes

Do you need to premedicate prior to dental care? (Heart Valve Replacement) (Artificial Joint Replacement)

Yes No

If yes

Have you taken any prescription drugs for weight loss?

Fenfluramine

Yes No

Fenfluramine W/ Phentermine(Fen-Phen)

Yes No

Dexfenfluramine (Redux)

Yes No

Is there anything you would like to discuss privately with Dr. Killian?

Yes No

If yes

Check Appropriate

Are you allergic to

Penicillin

Yes No

Metals

Yes No

latex

Yes No

Other Antibiotic Drugs

Yes No

Sulfa Drugs

Yes No

Local Anesthetics

Yes No

Lactose

Yes No

Red Dye

Yes No

Are you allergic to any medication / substance not listed?

Yes No

If yes

Do you have a food allergy?

Yes No

If yes

Do you have any of these related health conditions? Please check all that apply

Heart Disease

Yes No

Pacemaker

Yes No

Mitral Valve Prolapse

Yes No

Stroke

Yes No

Heart Murmurs

Yes No

Rheumatic fever

Yes No

High Blood Pressure

Yes No

Low Blood Pressure

Yes No

Radiation/Chemo

Yes No

Anemia

Yes No

Leukemia

Yes No

Diabetes

Yes No

Kidney problem

Yes No

Liver problem

Yes No

Asthma

Yes No

Fainting / Dizzy spells

Yes No

Epilepsy/Seizure

Yes No

Stomach Problems

Yes No

Psychiatric Treatment

Yes No

Breathing Problems

Yes No

Hepatitis

Yes No

Bleed Excessively

Yes No

Tuberculosis

Yes No

Thyroid Disease

Yes No

Drug/Alcohol Addiction

Yes No

HIV / AIDS

Yes No

Sexually Transmitted Disease

Yes No

Do you have any disease, condition or health related problem not listed on this form?

Yes No

If yes

I CERTIFY THE INFORMATION IS COMPLETE AND ACCURATE

Signature of Patient, Parent or Guardian:

X

Date: _____

AUTHORIZED BY

Signature of DENTIST SIGNATURE:

X

Date: _____