MEDICAL HISTORY

The human body is an interconnected marvel. No one part is isolated from another. No medication is without a possible side effect. No treatment is immune from its possible effect on other systems. Therefore, to render the best care is to have as full an understanding of a patient as possible. Please help us help you by answering these questions to the best of your ability. We'll be glad to help you as needed.

ARE YOU PRESENTLY ILL OR UNDER THE CARE OF A PHYSICIAN? ( )YES ( )NO
PLEASE EXPLAIN: _____

PHYSICIANS NAME: TYPE OF DR.: PHONE #:

DO YOU REQUIRE PRE-MEDICATION? ( ) NO ( ) DON'T KNOW ( ) YES: (medication)_____ Dosage_____

PLEASE CHECK THE APPROPRIATE BOX(s) BELOW OF ANY AND ALL OF THE FOLLOWING MEDICATIONS THAT APPLY TO YOU?

( ) BLOOD THINNERS
( ) INSULIN
( ) NERVE/ANXIETY MEDICATION
( ) STIMULENTS
( ) OTHER: _____
( ) CHEMICAL DEPENDENCY, NAME OF DRUG: _____
( ) MUSCLE RELAXERS
( ) PAIN KILLERS (including aspirin) TYPE_____
( ) TRANQUILIZERS

Do you have a list of your medications that we may copy and attach to this form? ( ) Yes ( ) No

PLEASE CIRCLE THE "Y" (yes) OR THE "N" (no) FOR THE FOLLOWING MEDICAL CONDITIONS, DISEASES OR PROCEDURES.

Y N ALCHOHOL ABUSE	**Y N** ANEMIA	**Y N** ARTIFICIAL BONES/JOINTS	**Y N** ARTIFICIAL VALVES
Y N ASTHMA	**Y N** ARTHRITIS/RHEUMATISM	**Y N** BACK PROBLEM	**Y N** BLEEDING ABNORMALITY
Y N BACK PROBLEMS	**Y N** BLEEDING PROBLEMS	**Y N** BLOOD DISEASE/DISORDER	**Y N** CANCER
Y N CANCER	**Y N** CHEMOTHERAPY	**Y N** CHEST PAIN	**Y N** CONGENITAL HEART DEFECT
Y N COBALT TREATMENT OR X-RAY	**Y N** COSMETIC SURGERY	**Y N** COUGH – CONSISTENT	**Y N** CHEWING TOBACCO
Y N DIABETES	**Y N** DIFFICULTY BREATHING	**Y N** EMPHYSEMA	**Y N** EPILEPSY
Y N FAINTING SPELLS	**Y N** FREQUENT NECK PAIN	**Y N** FREQUENT HEADACHES	**Y N** GLAUCOMA
Y N HEART SURGERY – VALVE	**Y N** HEART DISEASE	**Y N** HEPATITIS	**Y N** HERPES ORAL/COLD SORE
Y N HEART MURMUR	**Y N** HIGH/LOW BLOOD PRESSURE	**Y N** HIV – AIDS - ARC	**Y N** HYPOGLYCEMIC
Y N JAW ISSUES/TMJ/TMD CLENCHING/GRINDING	**Y N** JAW CLICKS OR POPS OUT OF SOCKET	**Y N** KIDNEY PROBLEMS	**Y N** LEUKEMIA
Y N LIVER PROBLEMS	**Y N** MITRAL VALVE PROLAPSE	**Y N** NECK OR EAR PAIN	**Y N** NERVOUSNESS
Y N PHYCHIATRIC TREATMENT	**Y N** RESPIRATORY PROBLEMS	**Y N** RHEUMATIC FEVER	**Y N** SCARLET FEVER
Y N SHINGLES	**Y N** SINUS PROBLEMS	**Y N** SMOKE TOBACCO	**Y N** STROKE
Y N SWOLLEN GLANDS/FEET/ANKLES	**Y N** THYROID PROBLEMS	**Y N** TUBERCULOSIS/TB	**Y N** TUMORS
Y N ULCER	**Y N** VENEREAL DISEASE	**Y N** CONTACT LENSES	**Y N** OSTEOPOROSIS MEDICATION

PLEASE LIST ANY OTHER MEDICAL CONDITION, PROCEDURE OR DISEASE YOU HAVE HAD: _____

Are you allergic to any of the following: ( ) LATEX ( ) PENICILLIN ( ) AMOXICILLIN ( ) ASPIRIN ( ) TETRACYCLINE ( ) DENTAL ANESTHETIC
( ) OTHER, please specify_____

Have you ever taken any group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin, (brand name of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine) YES_____ NO_____

FOR WOMEN: Are you taking birth control medication? ( ) Yes ( ) No Are you pregnant? ( ) Yes ( ) No Are you nursing? ( ) Yes ( ) No

We invite you to discuss with us any questions regarding our services. The best Dental Health Services are based on a friendly, mutual understanding between patient and provider.
I authorize the staff to perform any necessary services needed for diagnosis and treatment. I also authorize the provider to release any information required to process my insurance claims.
I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform Dr. Jermov's office of any and all changes to the information I have provided.

SIGNATURE: _____ **TODAY'S DATE:** _____

PRINTED NAME: _____ **DATE OF BIRTH:** _____