Turner P. Emery, D.D.S., M.D.
Joshua S. Manuel, D.D.S.

FOR INTERNAL USE

Date: ______________________ Chart #: ______________________

Doctor: ____

MEDICAL HISTORY

Patient Information

Patient Name (Please Print) First: MI: Last:	**Age**	**Preferred Pharmacy**
Referred by:	**Personal Dentist**	**Primary Care Physician**

Name, **Address** and **Phone** of a person outside your household who could help us in contacting you:

Have **you** or **your relatives** been treated by this offi e?

List reason(s) you have been referred to this offi e:

If Wisdom Teeth - please list symptoms & date symptoms began:

List the surgeries that you have had:

Did you have general anesthesia? ❑ Yes ❑ No

Medicines that you are presently taking (including birth control and any over the counter medicine such as aspirin, nutritional, herbal, or dietary supplement):

What medicines are you allergic to?
Penicillin Aspirin Demerol Codeine Sulfa Others?

Do you have a Latex allergy? ❑ Yes ❑ No

YES	NO	Are you taking or have you ever taken Bisphospho-nates (Fosamax, Actonel, for osteoporosis)?
YES	NO	Do you drink alcohol?
YES	NO	Do you use drugs?
YES	NO	Family history of bleeding or anesthesia reactions?
YES	NO	Are you being treated by a physician for any illness?
YES	NO	Do you wish to talk to the doctor privately about anything special?

Do you have or have you had any of the following:

YES	NO	Rheumatic Fever
YES	NO	High Blood Pressure
YES	NO	Stroke
YES	NO	Heart Disease (heart attack, murmur, angina, valve replace-ment, bypass surgery)
YES	NO	Lung Disease (asthma, emphysema, TB, etc.)
YES	NO	Epilepsy or seizures
YES	NO	Diabetes
YES	NO	Mental Illness/Handicap
YES	NO	Fever Blisters/Cold Sores
YES	NO	TMJ (Jaw Point) Problems
YES	NO	Bleeding Disorders
YES	NO	Have you ever had a Blood Transfusion?
YES	NO	Have you had a hip or joint replacement?
YES	NO	Immune Diseases
YES	NO	Do you smoke cigarettes, cigars, pipes or use smokeless tobacco?
YES	NO	Gastrointestinal disease (ulcers, colitis, diverticulitis)
YES	NO	Arthritis, if so, **what type:**
YES	NO	Kidney Disease
YES	NO	Liver Disease
YES	NO	Anxiety/Depression
YES	NO	Ladies - are you pregnant?

If due to an accident, please fill out this se tion

Accident Date	**Claim Adjuster's Name**	**Claim Adjuster's Telephone Number**
Claim Adjuster's Address		
Brief Description of Accident		

I understand the information I have provided on this form is essential to determine my surgical needs and that I have answered all questions truthfully. I will report any changes in my health history as soon as possible.

Signed ______________________________ Date ______________