YOUR FAMILY DENTIST, PC

DR. YATI YADAV, DDS, FAGD & ASSOCIATES

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MEDICAL HISTORY

Please complete the following confidential information

Patient's Name Last ______________________ First ______________________ MI ________

Physician's Name (MD) ______________________________ Date of Last Visit ____/____/____

Have you ever had any serious illness or operations? Yes _____ No _____ If yes, describe: ______________________

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Circle if you have or had any of the following:

Anemia	Cough up Blood	Jaw Pain	Scarlet Fever
Arthritis	Diabetes	Kidney Disease	Shortness of Breath
Artificial Heart Valves	Epilepsy	Liver Disease	Skin Pain
Artificial Joints	Fainting	Migraines	Special Diet
Asthma	Glaucoma	Mitral Valve Prolapse	Stroke
Back Problems	Headaches	Nervous Problems	Swollen Feet / Ankles
Blood Disease	Heart Murmur	Osteoporosis	Swollen Neck Glands
Cancer	Heart Problem	Pacemaker	Thyroid Problems
Chest Pain	Hemophilia	Persistent Cough	Tobacco Habit
Chemical Dependency	Hepatitis	Psychiatric Care	Tonsillitis
Chemotherapy	HIV/AIDS	Radiation Treatment	Tuberculosis
Circulatory Problems	High Cholesterol	Respiratory Disease	Ulcer
Cortisone Treatments	High Blood Pressure	Rheumatic Fever	Venereal Disease

(Women Only) Are you pregnant? Yes _____ No _____ If yes, approximate due date ______________________

Please explain items circled:

BEFORE ANY CLINICAL PROCEDURES, PATIENTS AT RISK OF INFECTIVE ENDOCARDITIS MUST BE PREMEDICATED WITH ANTIBIOTICS. (Initial) ____________

I have been informed that any antibiotics prescribed to me will reduce the effectiveness of birth control pills/ shots/ patches. (Initial if you are a woman of childbearing age) ____________

List any medications you are currently taking:

Check if you have/had taken any of the following:

Phen-fen _____; Didronel _____; Actonel _____; Kelid ____; Fosamax ____; Boniva ______; Aredia ____; Zometa ____

Allergies: Asprin ________ Barbiturates _________ Codeine _____ Latex(gloves)________ Penicillin _____
Local Anesthetics _____ Sulfa Drugs _________ Other ______________________________

I hereby authorize the doctors and/or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. The above information is accurate and complete to the best of my knowledge. I will not hold my dentist, Yati Yadav DDS, Your Family Dentist PC, or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Guardian: ______________________________________ **Date**: ____/____/____