MEDICAL HISTORY

Name_____ SS#_____ **Birthdate** _____

Address _____

Home Phone_____ **Cell Phone**_____ **Business Phone**_____

Employer_____

Occupation_____ **Referral Source**_____

Spouse or Close Relative_____ **Their Phone#**_____

E-mail Address_____

1. Please (circle) below if you are allergic or have ever had a reaction to:

Local Anesthetics Aspirin Codeine Metals Latex Penicillin Sulfa or other Antibiotics

Other Allergies _____

2. Please (circle) below MEDICATIONS you are currently taking:

Heart Medicine:

Digitalis (Digoxin, Lanoxin) Isordil

Nitroglycerin Inderal

High Blood Pressure Medicine:

Diuretics, Water Pills (Lasix, Hydrodiuril)

Blood Thinners (Heparin, Coumadin, Plavix)

Asthma Medicine (Aminophyline)

Other Medicine:

Glaucoma Eye Drops

Epilepsy Medicine (Dilantin)

Diabetic Medicine (Insulin, Other)

Narcotics, Pain Pills or Shots

Aspirin or Anti-Inflammatory Drugs

Arthritis Medicine

Birth Control

Steroids (Prednisone)

Sleeping Pills

Tranquilizers

Anti-depressants

Diet Pills (Fen-Phen, Redux, etc.)

Medicine for Osteoporosis (Fosamax, Boniva, Actonel)

Allergy Medications

Please note any other medicine, NOT LISTED including herbs, vitamins, & over the counter medications: _____

_____

3. Please (circle) below any condition you have had or have now:

Stroke	High Blood Pressure	Neurological Problems	Bleeding Problems	Rheumatic Fever
Asthma	Hormonal Disorders	Cancer	Prostate Problems	Breast Implants
Jaundice	Hepatitis	Diabetes	Radiation Therapy	Joint Replacement
Anemia	Herpes	Tuberculosis	Eye Disorders	Mitral Valve Prolapse
Colitis	Prone to Infection	Venereal Disease	Eating Disorders	Any Heart Ailments or Heart Murmur
Arthritis	Stomach Ulcers	Chemotherapy	TMJ (jaw joint) Problems	_____
Epilepsy	Kidney Disease		HIV or AIDS	_____
Thyroid			Gastric Bypass	_____

4. Please (circle) if any of the following bother you frequently:

Ear Problems	Severe Headaches	Convulsions	Dry Mouth	Bruise Easily
Chest Pains	Dizziness or Fainting	Persistent Coughing	Rashes, Hives	
Nose Bleeds	Irregular Heart Beats	Shortness of Breath	Other: _____	

5. Have you been hospitalized in the last 5 years?_____ If yes, for what reason? _____

6. For women – Is there any possibility you are or may be pregnant?_____

7. Do you smoke or use tobacco products? _____

8. Have you ever been told to be premedicated before dental treatment?_____

MICHAEL W. JORY, D.M.D., INC.
DAVID G. GIFFORD, D.D.S.
4549 QUAIL LAKES DRIVE ▪ STOCKTON, CALIFORNIA 95207 ▪ 209.478-1136

I hereby certify that this information is true and correct and authorize Dr. Gifford and/or Dr. Jory do all necessary dental services. Consent shall remain in force until cancelled.

Signature of Patient or Guardian_____ Date_____

I, _____, hereby authorize payment directly to Dr. Gifford or Dr. Jory for group insurance benefits otherwise due me. Insured Signature _____

Changes: _____

_____

Signature_____ Date_____

Changes: _____

_____

Signature_____ Date_____

Changes: _____

_____

Signature_____ Date_____

Changes: _____

_____

Signature_____ Date_____

Changes: _____

_____

Signature_____ Date_____

History reviewed on:

__/__/____ by_____ __/__/____ by_____ __/__/____ by_____ __/__/____ by_____ __/__/____ by_____

MICHAEL W. JORY, D.M.D., INC.
DAVID G. GIFFORD, D.D.S.
4549 QUAIL LAKES DRIVE ▪ STOCKTON, CALIFORNIA 95207 ▪ 209.478-1136