HUGH MARCHMONT-ROBINSON, D.D.S., S.C. 3302 GROVE AVENUE • BERWYN, ILLINOIS 60402 • (708) 788-8200

(PLEASE PRINT)

Reason for today's visit_____

Referring Dentist_____ Phone (_____) _____

Check(✓) if you have had problems with any of the Following:

☐ Pain in teeth or gums ☐ Clicking or popping jaw ☐ Loose teeth or broken teeth

MEDICAL HISTORY

Physician's Name_____ Phone (_____)_____ Date of last visit_____

Are you currently under any active treatment? ☐ Yes ☐ No

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, Describe_____

_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes give approximate dates_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?"

These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluaramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you Ever taken any herbal supplements? ☐ Yes ☐ No

Tobacco use? ☐ Yes ☐ No Alcohol? ☐ Yes ☐ No

(Women) Are you Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had any of the following diseases or disorders:

☐ Blood Diseases
- ☐ Anemia
- ☐ Bleeding
- ☐ Hemophillia

☐ Cancer
- Type_____
- Year_____
- ☐ Chemotherapy
- ☐ Radiation Therapy

☐ Chemical Dependency

☐ Circulatory Problems
- ☐ High Blood Pressure
- ☐ Leg Cramps
- ☐ Phlebitis
- ☐ Stroke

☐ Cortisone Treatment

☐ Endocrine Disorders
- ☐ Diabetes
- ☐ Thyroid

☐ Eye Disorder

☐ Gastrointestinal Disorders
- ☐ Colitis/Crohns
- ☐ Diverticulitis
- ☐ Gastritis
- ☐ Ulcers

☐ Gynecological Problems

☐ Heart Problems
- ☐ Angina, Chest Pain
- ☐ Angioplasty When?_____
- ☐ Arrhythmia
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Mitral Valve Prolapse
- ☐ Murmur
- ☐ Pacemaker
- ☐ Rheumatic Fever/Heart Disease
- ☐ Surgery
  - ☐ Bypass Year_____
  - ☐ Valve Replacement/Repair Year_____

☐ Infectious Diseases
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Sexually Transmitted (STD)
- ☐ Tuberculosis

☐ Kidney Disease

☐ Liver Disease
- ☐ Hepatitis
- ☐ Cirrhosis

☐ Musculoskeletal Disorders
- ☐ Arthritis
- ☐ Artificial Joints When?_____
- ☐ Myalgia

☐ Nervous System
- ☐ Chronic Pain
- ☐ Dizziness
- ☐ Fainting
- ☐ Epilepsy
- ☐ Headaches

☐ Prostate Problems

☐ Psychiatric Treatment

☐ Respiratory Diseases
- ☐ Asthma
- ☐ Bronchitis, COPD
- ☐ Cough, chronic, bloody, sputum
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Sinusitis

☐ Skin Disorders

Do you have any medical condition not covered in this questionnaire?

☐ Yes ☐ No

If so, What? _____

_____

_____

_____

_____

_____

_____

PLEASE FILL OUT OTHER SIDE

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

☐ Local Anesthetic ☐ Penicillin

☐ Latex _____

☐ Other _____

_____

_____

_____

_____

SIGNATURE

The information on the FRONT and BACK of this form is accurate and complete to the best of my knowledge. I certify that I speak, read and write English and have read and fully understand this Medical History form. I will not hold my Dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ **X** _____

Signature of Patient

Date_____ **X** _____

Signature of Guardian

Date_____ **X** _____

Signature of Doctor