Dr. Jason Petkevis, DMD LLC.

Medical History

Patient Name:________________________________

1. Physician's Name ____ Phone (   ) ____________________
Have you had any medical care within the past two years?……………………………………………………………Yes No
Describe____
2. Have you taken any medication or drugs during the past two years?……………………………….…….……….…Yes No
If yes, please list name and dosage____
3. Are you taking any medications, drugs, pills or herbal remedies, including regular doses of aspirin?……….…….….…..Yes No
If yes, please list name and dosage____
4. Have you taken prescription medications for weight loss (diet pills)?…………………………………………….…Yes No
If yes, did you take any of the following:(circle if yes) Fen-Phen Pondimen Redux Other
If yes to any of the above, did you have a medical exam for heart issues?……...…………..……………………………...Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?……………Yes No
6. Have you been a patient in the hospital during the past five years?……………………………………………………..Yes No

7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (surgery, disease, attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	AIDS/HIV Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold sores/fever blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact Lenses	Yes	No	Blood transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Jaundice	Yes	No
Cortisone Medication	Yes	No	Hay Fever/allergy	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or dizzy spells	Yes	No
Diet (special/restricted)	Yes	No	Radiation therapy	Yes	No	Nervous/anxious	Yes	No
Artificial joints (hip, knee, ect.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/		
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychological Care	Yes	No

8. Are you aware of having an allergic (or adverse) reaction to any substance or medication?……………..……………..Yes No
9. Have you lost or gained more than 10 pounds in the past year?…………………………………………………...Yes No
10. Do you have or have your had any disease, condition, or problem not listed?…………………………………………Yes No
If yes, please list:____
11. Women: are you pregnant or think you could be pregnant? Yes _______ Months No Nursing? Yes No
12. Do you use birth control prescriptions?……………………………………………………………………….…. Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient Signature/ Responsible Party Signature____ Date____________________

History Review

Dentist signature____ Date_________________________