# Aquia Dental Care

Norma D. Gutierrez, D.D.S.

## Medical History Update

Patient Name (Please Print Clearly): ___________________________________________________________________

Physician's Name ______________________ Phone Number _______________

Have you had any serious illnesses or operations? ________If yes, please describe:

____________________________________________________________________________________________________

Have you ever had a blood transfusion? Yes No If yes, give approximate dates__________

**(Women)** Are you pregnant? Yes No Nursing? Yes No

Please **circle** Yes or No if you have or have had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Anemia or Blood Disorder? | Yes | No | Hepatitis, Any Form | Yes | No |
| Arthritis or Rheumatism | Yes | No | Joint Replacement | Yes | No |
| Asthma | Yes | No | Kidney Disease | Yes | No |
| Cancer | Yes | No | Liver Disease | Yes | No |
| Diabetes | Yes | No | Psychosis | Yes | No |
| Respiratory/Lung Illness | Yes | No | Previous Biopsies | Yes | No |
| Epilepsy | Yes | No | Radiation or Chemotherapy | Yes | No |
| Glaucoma | Yes | No | Rheumatic Fever | Yes | No |
| Heart Valve (artificial) | Yes | No | H.I.V/Aids or ARC | Yes | No |
| Heart Disease or Heart Attack | Yes | No | Other: | Yes | No |
| High Blood Pressure | Yes | No | | | |

Please list any Medications you are taking, and for what purpose:

Please **circle** Yes or No if the following apply:

Do you use tobacco? Yes No If yes, circle type: Smoke Chew How much per day? ________________

Do you consume Alcohol? Yes No If yes, approximately how many alcoholic beverages per week? ____________

Do you use recreational drugs? Circle answer: Yes No

Are you allergic to?

| | | | | | |
|---|---|---|---|---|---|
| Local anesthetics | Yes | No | Codeine, Valium, or other sedatives | Yes | No |
| Penicillin or other antibiotics | Yes | No | Latex or Metals | Yes | No |
| Aspirin, Ibuprofen, or Tylenol | Yes | No | Other (please specify) | | |

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 knowledge.

_________________________________ _________________________________ ________________

Patient/Legal Guardian Printed Name Patient/Legal Guardian Signature Date

Office Use:

________________ ________________ __________ _________________

ASA Assistant lbs (if child) Date

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