BEAUTIFULsmiles™

Patient's Name_____

Medical Information (continued)

Women, are you... *(please circle all that apply)* ☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following? *(please check all that apply)* ☐ Penicillin ☐ Sulfa Drugs ☐ Latex ☐ Codeine
☐ Other_____

What pharmacy do you prefer to use for your prescriptions? Pharmacy Name _____
Pharmacy Phone #_____

Do you have, or have you had, any of the following? *(please check all that apply)*

☐ Aids/HIV	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Rheumatic Fever	☐ Angina
☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism	☐ Arthritis/Gout
☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever	☐ Artificial Heart Valve
☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles	☐ Artificial Joint
☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease	☐ Asthma
☐ Fainting Spells/Dizziness	☐ Irregular Heart Beat	☐ Sinus Trouble	☐ Blood Disease
☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida	☐ Blood Transfusion
☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach/Intestinal Disease	☐ Breathing Problems
☐ Frequent Headaches	☐ Liver Disease	☐ Stroke	☐ Bruise Easily
☐ Low Blood Pressure	☐ Swelling of Limbs	☐ Cancer	☐ Glaucoma
☐ Lung Disease	☐ Thyroid Disease	☐ Chemotherapy	☐ Hay Fever
☐ Mitral Valve Prolapse	☐ Tonsillitis	☐ Chest Pains	☐ Heart Attack/Failure
☐ Osteoporosis	☐ Tuberculosis	☐ Cold Sores/Fever Blisters	☐ Heart Murmur
☐ Pain in Jaw Joints	☐ Tumors or Growths	☐ Congenital Heart Disorder	☐ Heart Pacemaker
☐ Parathyroid Disease	☐ Ulcers	☐ Convulsions	☐ Heart Trouble/Disease
☐ Psychiatric Care	☐ Yellow Jaundice	☐ Eating Disorder	☐ Alcohol Abuse
☐ Colitis	☐ Difficulty Breathing	☐ Heart Surgery	☐ Human Papilloma Virus

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If Yes, Explain_____

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Beautiful Smiles of any changes in my medical status.

Signature of Patient, Parent or Legal Guardian_____ Date_____