



*Beautiful Smiles are our Business*

**Dr. Robert R. Burks**

Winter Springs Town Center

(407) 327-2030

[www.DrRobertBurks.com](http://www.DrRobertBurks.com)

**Quality Dentistry with A Gentle Touch...**

**That is our Commitment to You!**

## Confidential Medical History

Name \_\_\_\_\_ Date \_\_\_\_\_

Email Address \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes, please list: \_\_\_\_\_

Do you take, or have you taken, medications for osteoporosis?  Yes  No If yes, please explain: \_\_\_\_\_

Are you on a special diet?  Yes  No If yes, please explain: \_\_\_\_\_

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

Women: Are you:

Pregnant/Trying to get pregnant?  Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Jewelry  Latex  Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

<input type="checkbox"/> AIDS/HIV/ Positive	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Medication	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Snoring nightly
<input type="checkbox"/> Angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Pain in Jaw Joint	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive daytime drowsiness	<input type="checkbox"/> Herpes	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Shingles	

Have you ever had any serious illness not listed above?  Yes  No If Yes, Please 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 the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_