FRIEDMAN • GRATER • WILLIAMS
FAMILY DENTISTRY
4129 Locust Lane Harrisburg, PA 17109
Phone (717) 657-3326 www.friedmangrater.com

Patient Name_____ Date_____

Medical History

1. Are you under the care of a physician? Yes No
2. Name of family physician?_____
3. Are you taking any kind of medication (prescribed or unprescribed) at this time? Yes No
   If yes, please list_____
4. Are you allergic to or have had any unusual reactions to any drugs, medications or materials? Yes No
   If yes, please list_____
5. Have you been hospitalized, or had surgery or anesthesia in the last five years? Yes No
   If so, when? _____
   For what reason? _____
6. Are you taking birth control? Yes No Are you pregnant? Yes No
7. Circle the following which you have had or presently have:

High Blood Pressure	Anemia	Hepatitis
Heart Disease	Stroke	Liver Disease
Angina	Kidney Trouble	Jaundice
Congestive Heart Failure	Emphysema	Blood Transfusions
Heart Surgery	Chronic Cough	Drug Addiction
Heart Pacemaker	Tuberculosis	Alcohol Abuse
Artificial Heart Valves	Asthma	Psychiatric Treatment
Heart Murmur	Hay Fever	Hemophilia
Rheumatic Fever	Sinus Trouble	Bleeding Disorders
Artificial Joints	Allergies/ Hives	Venereal Disease
Mitral Valve Prolapse	Diabetes	Cold Sores/ Oral Ulcers
Cancer	Arthritis	Gastrointestinal Ulcers
Chemotherapy	Glaucoma	Epilepsy
Radiation Therapy	HIV/ AIDS	Fainting/ Dizziness

For Office Use:
Medical History Updates
1._____
2._____
3._____
4._____
5._____
6._____

8. Have you ever taken Fen-Phen or Redux? Yes No
9. Do you have any disease, condition or problem not listed above? Yes No
   If so, please list_____
10. Have you ever taken intravenous or oral bisphosphonates/osteoporosis medications? Yes No
    If so please describe_____
11. Are you currently taking Plavix, Coumadin, Warfarin, or any blood thinners? Yes No
    If yes, please list_____

Dental History

1. When was your last visit to the dentist?_____
2. Name of previous dentist and location_____
3. When did you last have dental x-rays?_____
4. Do you have any dental complaints at this time? Yes No
   If so, please describe_____
5. Do your gums bleed while brushing or flossing? Yes No
6. Have you ever had bad reactions to dental anesthetics? Yes No
7. Are you apprehensive about dental care? Yes No

*Signature*_____ *Doctor Signature* _____