**John L. Pournelle, Jr. D.M.D**

# DENTAL AND MEDICAL INITIAL HISTORY AND UPDATES

**PATIENT NAME______________________________ DATE_____________**
Address___________________________________________________
City_______________________ State________ Zip Code_____________
Date of Birth________ Home / Cell Phone ____-____-____ Work Phone.____-____-____
Patient's SS# ____________-____________-___________

## MEDICAL HISTORY

Who is your medical physician?_____________________________________________
Are you under a physician's care now? Why? Who? ____________________________
Have you ever been hospitalized or had a major operation or injury? ________________
Are you taking any medications, pills, or drugs? What? ____________________________
_____________________________________________________________________
Are you allergic to any medications or substances? Please circle.
**Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other____________**
Do you use (circle all that apply) **Tobacco Alcohol Drugs**
Women (Circle) **Pregnant Trying to conceive Nursing Taking Oral Contraceptives**

**__Please circle any medical conditions present or past__**

*If yes to any of the starred conditions, please call prior to your appointment Premedication may be required*

| | | | |
|---|---|---|---|
| Heart Trouble/Disease | Bruise Easily | Sinus Trouble | Hepatitis A |
| *Heart Murmur | Anemia | Emphysema | Hepatitis B |
| Irregular Heart Beat | Excessive Bleeding | Tuberculosis | Hepatitis C |
| Sickle Cell Disease | Cancer | Kidney Problems | Cold Sores |
| Heart Attack/Failure | Hemophilia | Radiation Treatment | Renal Dialysis |
| Leukemia | Chemotherapy | Thyroid Disease | Herpes |
| Blood Transfusion | Stomach Disease | Parathyroid Disease | Stroke |
| Mitral Valve Prolapse | Ulcers | *Scarlet Fever | Swelling of Limbs |
| Liver Disease | Convulsions | Blood Disease | *Artificial Heart Valve |
| AIDS | HIV Positive | Fever Blisters | Lung Disease |
| Arthritis/Gout | Epilepsy | Fainting/Dizziness | *Heart Pace Maker |
| Breathing Problem | Frequent Diarrhea | Rheumatism | Glaucoma |
| *Heart Surgery | Shortness of Breath | Diabetes | Pain in Jaw Joints |
| Psychiatric Care | High Blood Pressure | Low Blood Pressure | Frequent Cough |
| Excessive Thirst | Tumors | Nervousness | Hay Fever |
| Hypoglycemia | Asthma | Venereal Disease | Sleep Disorder |
| Angina/Chest Pain | Alzheimer's Dementia | *Artificial Joint Replacement | |
| *Organ Transplantation | | | |

Have you ever had any other serious illness not indicated above? _______________________________
I have no medical problems, PLEASE INITIAL_____________

**To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I agree to inform the dentist and staff at the next appointment without fail.**

_____________________________________________________________________
**Patient's Signature (Parent or Guardian, If Minor)**

Dr. John L. Pournelle Jr., D.M.D