

MEDICAL HISTORY... ALLERGIES...

Do you consider your current overall physical health to be:

- Good Fair Poor

Are you currently under the active care of a physician or do you have any present health issues? Yes No

Please explain: _____

Do you need to be pre-medicated with antibiotics for any heart or other medical conditions prior to dental treatment? Yes No

Are you taking any prescription or over-the-counter medications? (including Ibuprofen, diet supplements, etc.) Yes No

Please list each one: _____

Are you pregnant or nursing? Yes No

If pregnant, which trimester? 1st 2nd 3rd

What is your due date? _____

Have you ever had any of the following illnesses or medical problems in the past? Please check Yes or No:

| Y | N | | Y | N | |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol/Drug Abuse | <input type="checkbox"/> | <input type="checkbox"/> | HIV+/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Hospitalization for any reason |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain/TMJ |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Bones/Joints/Valves | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Low Back/Hips/Leg Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Athletes Foot | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone/Joint Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Bursitis | <input type="checkbox"/> | <input type="checkbox"/> | Neck/Shoulder/Arm Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker/ICD |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic/Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Shingles |
| <input type="checkbox"/> | <input type="checkbox"/> | Gingivitis or Periodontal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | Spasms/Cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Sprains/Broken Bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Tendonitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis ____ Type | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB) |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes/Fever Blisters | <input type="checkbox"/> | <input type="checkbox"/> | Tumors |
| <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |

Please list any significant medical condition(s) or surgeries that you have had (not already listed): _____

Are you allergic to any of the following:

| Y | N |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Sulfites

| Y | N |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

- Latex
- Penicillin
- Tetracycline
- Any Metals
- Other

Please list any other drugs or items that you are allergic to: _____

Have you ever taken any of the following?

- Phen-Fen Vioxx Fosamax Cortico -Steroids Tetracycline

Cosmetic Implant Family

DENTISTRY

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