kramer irby d.d.s.

MEDICAL HISTORY

Patient's Name:
First _____ Middle Initial_____
Last _____

1. Physician's Name _____		
2. Are you under a physician's care?	YES	NO
Since when? _____		
Why?_____		
3. When was your last complete physical?_____		
4. Are you taking any medications or substances?	YES	NO
(If yes, please list medications in comments section.)	YES	NO
5. Do you routinely take health related substances?	YES	NO
6. Are you allergic to any medications or substances?	YES	NO
7. Do you have any other allergies?	YES	NO
8. Do you have any problems with penicillin, antibiotics, anesthetics, or other medications?	YES	NO
9. Are you allergic to latex?	YES	NO
10. Are you allergic to metal?	YES	NO
11. Are you pregnant or suspect you may be?	YES	NO
12. Do you use birth control medication?	YES	NO
13. Do you have heart problems?	YES	NO
14. Do you have a pacemaker or artificial heart valve implant?	YES	NO
15. Have you ever had rheumatic fever?	YES	NO
16. Are you aware of any heart murmurs?	YES	NO
17. Do you have HIGH or LOW blood pressure?	YES	NO
18. Have you ever had a serious illness or major surgery?	YES	NO
(If yes, please explain in the comments section.)		
19. Have you ever had a radiation treatment, chemo, treatment for tumor, growth or other condition?	YES	NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism?	YES	NO
21. Do you have any artificial joints / prosthesis?	YES	NO
22. Do you have blood disorders, such as anemia or leukemia?	YES	NO
23. Have you ever bled excessively after being cut or injured?	YES	NO
24. Do you have any stomach problems?	YES	NO

Comments

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Baton Rouge, LA 70806
Email: info@batonrougesmile.com
Phone: (225) 926-1059
Fax: (225) 924-6570

25. Do you have any kidney problems? YES NO
26. Do you have any liver problems? YES NO
27. Are you diabetic? YES NO
28. Do you have asthma? YES NO
29. Do you have epilepsy or seizure disorders? YES NO
30. Do you, or have you, had a venereal disease? YES NO
31. Have you tested HIV positive? YES NO
32. Do you have Hepatitis? YES NO
33. Do you, or have you, had Tuberculosis (TB)? YES NO
34. Do you smoke, chew, use snuff or any form of tobacco? YES NO
35. Have you ever used any weight loss products? YES NO
36. Do you have any diseases, conditions, or problems not listed? YES NO

(If so, please explain in the comments section.)

37. Is there anything else we should know about your health that was not covered? YES NO
38. Do you want to privately speak to Dr. Irby about a problem? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient / Guardian's Signature_____

Date _____

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