Arthur R. Kremer, DDS

Medical History

Patient Name: _____

Physician Name: _____

Last Medical Visit: _____

Women Only:

Are you Pregnant?	YES	NO
Are you currently nursing?	YES	NO
Do you take Birth Control?	YES	NO

Do you Smoke?	YES	NO
Drink more than 2 drinks/day?	YES	NO
Use Recreational Drugs?	YES	NO

*If yes, describe*_____

_____

Are you allergic to **Latex**, which is used in many dental products including gloves?

YES NO

Please list all medications you are currently taking and the conditions you take them for:_____

_____

_____

Have you been hospitalized in the last 2 years? YES/NO Why?_____

List any allergies you have: _____

_____

Indicate which of the following you have had, or have at present: (circle all that apply)

Allergies or Hives	Circulatory Problems	Hemophilia	Rheumatic Fever
Anemia	Cold Sores	Hepatitis	Scarlet Fever
Anxiety	Congenital Heart Defect	High Blood Pressure	Shortness of Breath
Arthritis/Rheumatism	Diabetes	HIV Positive	Sinus Problems
Artificial Heart Valves	Epilepsy	Jaw Pain	Skin Rash
Artificial Joints	Fainting	Kidney Trouble	Snoring
Asthma	Gastric Reflux	Liver Disease	Stroke
Back Problems	Glaucoma	Mitral Valve Prolapse	Thyroid Problems
Blood Disease	Headaches	Neurological Problems	Tonsillitis
Cancer	Heart Murmur	Pacemaker/Defibrillator	Tuberculosis
Chemical Dependency	Heart Attack	Psychiatric Care	Ulcers
Chemotherapy	Heart Problems	Radiation Treatment	Other

Other, Please Describe: _____