AMANDA G. MAYES D.M.D.
DENTISTRY

2520 Perry Avenue, Suite A
Bremerton, WA 98310
info@amandagmayes.com
www.amandagmayes.com
Phone (360)479-2240
Fax (360)792-5952

PATIENT INFORMATION

Name: _____ Birthdate: ____/____/____ Today's Date ____/____/____
Email Address:_____ I'd like to receive e-mail confirmations ❑Yes ❑ No

Medical History

Your current physical health is: ❑ Good ❑ Fair ❑ Poor
Are you under the care of a physician? ❑ Yes ❑ No
Please explain:_____
Date of your last physical exam_____
Physician's Name:_____
Phone #: (_____)_____
Do you smoke/use tobacco in any other form? ❑ Yes ❑ No
Have you ever taken bisphosphonate medications for conditions such as osteoporosis or osteopenia? ❑ Yes ❑ No
Have you ever taken Redux or Phen-fen ❑ Yes ❑ No
Have you received IV chemo for cancer ❑ Yes ❑ No

Do you have allergies to any of the following?

Aspirin	Y	N	Sulfa drugs	Y	N
Latex	Y	N	Dental Anesthetics	Y	N
Penicillin	Y	N	Codeine	Y	N
Seasonal	Y	N	Other	Y	N

Please list additional drugs that cause allergic or adverse reactions:_____
For Women: Are you pregnant? ❑Yes ❑No
Are you nursing? ❑ Yes ❑ No
Are you taking birth control pills? ❑ Yes ❑ No

Please list any medications, drugs or pills you are currently taking including over the counter and herbal remedies:

_____

_____

Have you experienced the following diseases or medical conditions? Circle Yes or No for each item.

Asthma	Y	N	Digestive disorder	Y	N	Radiation Treatment	Y	N
Bleeding disorder	Y	N	Colitis/Ulcers	Y	N	Liver Disease/Jaundice	Y	N
Blood transfusion	Y	N	Glaucoma	Y	N	Hepatitis Type_____	Y	N
Anemia	Y	N	Emphysema	Y	N	Viral Infections	Y	N
Heart Disease	Y	N	Persistent Cough	Y	N	HIV+/AIDS	Y	N
High/low blood pressure	Y	N	Difficulty Breathing	Y	N	Venereal Disease	Y	N
Heart Attack	Y	N	Tuberculosis (TB)	Y	N	Herpes/Cold Sores	Y	N
Heart Surgery	Y	N	Osteoporosis	Y	N	Epilepsy/Seizures	Y	N
Heart murmur	Y	N	Thyroid Problem	Y	N	Fainting Spells	Y	N
Infective Endocarditis	Y	N	Hormone deficiency	Y	N	Head/Neck Injuries	Y	N
Artificial valves	Y	N	Arthritis/Rheumatoid	Y	N	Frequent/Severe Headaches	Y	N
Pacemaker	Y	N	Steroid Therapy	Y	N	Neurological Conditions	Y	N
Congenital Heart Defect	Y	N	Sinus Problems	Y	N	Psychiatric Problems	Y	N
High cholesterol	Y	N	Cancer	Y	N	Alcohol/Drug Abuse	Y	N
Stroke	Y	N	Tumors/Abnormal Growths	Y	N	Diabetes	Y	N
Kidney problems	Y	N	Chemotherapy	Y	N	Artificial Joints/Bones	Y	N

Please list any hospitalizations or major surgeries in the last five years: _____
_____
List any medical condition, disease or problem not listed that you have experienced: _____
_____
I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Signature of Patient, Parent or Guardian: _____Date:_____

History Review: