STEVEN D. PENDLETON D.D.S., P.A.
www.stevenpendletondds.com
9000 State Ave. Kansas City, Kansas 66112 (913) 299-0704

Name of Patient_____ Date of Birth____/____/____
First Middle Last

Patient Medical History

Primary Physician:_____ Phone:_____ Last Exam Date:_____

1) Are you under medical treatment now? Yes No
Reason:

2) Are you currently taking any medications, including non-prescription medicine? Yes No
PLEASE LIST:

_____ _____
_____ _____
_____ _____

3) Are you taking any blood thinners? Yes No
4) Do you use tobacco? Yes No Do you use alcohol? Yes No Do you use recreational drugs? Yes No
5) Are you pregnant or may be pregnant? Yes No Due date:_____ Are you nursing (breast feeding? Yes No
6) Have you ever been hospitalized for any surgery or illness? Yes No
If so, please list reason and date:

7) Have you been diagnosed with any mental, physical, or developmental disorders? Yes No
Please describe:_____
8) Are you allergic to or have you had any reactions to the following:

	Yes	No		Yes	No		Yes	No
Penicillin			Pain medications			Novocain or local anesthetics		
Other antibiotics			What kind:			Sulfa Drugs		
What kind:			Codeine			Sedatives		
			Aspirin			Latex		

9) Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Angina/Chest Pains			Hepatitis			AIDS/HIV		
Cardiac Pacemaker			Type: A B C D			Anemia		
Heart Attack			Jaundice			Sickle Cell Anemia		
When:			Liver Disease			Arthritis		
Heart Disease			Joint Replacement			Asthma		
Heart Murmur			What:			Emphysema / COPD		
Heart Trouble			When:			Respiratory Problems		
High Blood Pressure			Implant			Tuberculosis		
Low Blood Pressure			Organ Transplant			Diabetes		
Swollen Ankles			Cancer			Epilepsy / Convulsions		
Rheumatic Fever			Kind:			Fainting / Seizures		
Stroke			When:			Lupus		
When:			Leukemia			Glaucoma		
Stomach Trouble/Ulcers			Radiation Therapy			Kidney Disease		
TMJ / TMD Problems			Thyroid Problems			Recent Weight Loss		

Authorization and Release of Records
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

_____ _____
Signature of (circle one): Patient Legal Guardian Responsible Party Date

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