Marina Bay Dental Associates P.C.
308 Victory Road • Quincy, MA 02171

Patient Name: _____
Last First Date of Birth

Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____

Are you under a physician's care? (Other than yearly checkups) ☐Yes ☐No **if yes, When?**

Why?

1. In what year was your last physical exam? ....**19 , 20 ☐ don't remember**
2. Are you taking any medications or substances? ..... ☐Yes ☐No **if yes, explain:**
3. Are you allergic to any medications or substances?..... ☐Yes ☐No **if yes, explain:**
4. Do you have any other allergies? ..... ☐Yes ☐No
5. Do you have any problems with penicillin, antibiotics, anesthetics, etc.? ..... ☐Yes ☐No **if yes, explain:**
6. Are you sensitive to any metals or latex? ..... ☐Yes ☐No
7. Are you pregnant or suspect you may be?..... ☐Yes ☐No
8. Do you use birth control medication?..... ☐Yes ☐No
9. Have you been treated for or have been told you have heart disease?..... ☐Yes ☐No
10. Do you have a pacemaker or an artificial heart valve implant? ..... ☐Yes ☐No
11. Any history of rheumatic fever or heart murmurs?..... ☐Yes ☐No
12. Have you ever had a serious illness or major surgery?..... ☐Yes ☐No **if yes, explain:**
13. Have you ever had radiation or chemo treatment for tumor, growth, etc?..... ☐Yes ☐No
14. Do you have inflammatory disease such as arthritis or rheumatism?..... ☐Yes ☐No
15. Do you have any artificial joints or prosthesis? ..... ☐Yes ☐No
16. Do you have any blood disorder such as anemia, leukemia, etc? ..... ☐Yes ☐No
17. Have you ever bled excessively after being cut or injured? ..... ☐Yes ☐No
18. Do you have any stomach, kidney or liver problems? ..... ☐Yes ☐No
19. Are you diabetic? ..... ☐Yes ☐No
20. Do you have asthma? ..... ☐Yes ☐No
21. Do you have epilepsy or seizure disorders? ..... ☐Yes ☐No
22. Have you tested positive for HIV? ..... ☐Yes ☐No
23. Do you have AIDS? ..... ☐Yes ☐No
24. Have you have or had tested positive for Hepatitis?..... ☐Yes ☐No
25. Do you have or had T.B.? ..... ☐Yes ☐No
26. Do you smoke, chew, use snuff or any other form of tobacco?..... ☐Yes ☐No **if yes, how often:**
27. Do you consume alcoholic beverages? ..... ☐Yes ☐No
28. Have you had psychiatric treatment? ..... ☐Yes ☐No **if yes, explain:**
29. Do you have any disease, condition, or problem not listed? ..... ☐Yes ☐No **if yes, explain:**
30. Is there anything else we should know about your health?..... ☐Yes ☐No **if yes, explain:**

I Certify that the above information is Complete and Accurate

Patient/Guardian Signature: _____ Date _____

Dentist Signature: _____Date _____

MEDICAL HISTORY 20_____