THE EXTRA SMILE

Medical Information

Name:_____ Date of birth; ___/___/___ Weight :_____Height:_____

Emergency Contact:_____ Relationship:_____ Phone_(___)_____

Primary Physician:_____ Last visit date:___/___/___ Phone(___)_____

Specialist Physician(s):_____ last visit date ___/___/___ Phone(___)_____

1. Do you suffer from or have you been treated for any of the following:

Cardiovascular	Yes	Nervous System	Yes	Respiratory	Yes	Endocrine	Yes
CAD (angina, heart attack)		Seizures/Epilepsy		COPD		Thyroid Disorder	
Heart Failure (weak Heart)		Depression or panic attacks		Emphysema		Diabetes Mellitus	
High Blood Pressure		Psychosis or Mania		Chronic Bronchitis		Immune System	
Low Blood pressure		Multiple Sclerosis		Asthma		Pregnant	
Arrhythmias (irregular beat)		Headaches/ Migraines		Sinus/ Hay fever		Breast Feeding	
Congenital Heart defect		Substance Abuse		Obstructive sleep		**Excretory**	
Valve Disease or Murmur		Alzheimer's\other Dementia		Allergies\ Inhaler		Liver disorder	
Artificial heart valve		Physical\Mental Impairment		**Miscellaneous**		Kidney Disorder	
Endocarditic (Heart infection)		**Infections**		Cancer		Bladder Disorder	
Stroke Or TIA		Hepatitis		Joint replacement		Ulcers or GRED	
Bleeding problems		HIV\AIDS		Organ Transplant		Intestinal Problems	
Blood cell Disorder		Tuberculosis		Glaucoma			

2. Please list any medical problems you have that are not listed in this table:

3. Have you ever Received a Local Anesthetic? Y [ ] N [ ] General Anesthetic? Y [ ] N [ ] Any problems Y [ ] N [ ]

4. Please list any allergies to medication, foods or any other substances:_____

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5. Please list ALL medication you are taking, including non-prescription product;_____

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