THE DENTAL LAB

Dr. Karen Erani, DMD

MEDICAL HISTORY

Patient's Last Name _____ MI ___ First Name _____

Are you currently under the care of a physician? ☐ Yes ☐ No

For what reason? _____

When was your last physical exam? _____

Physician's Name _____ Phone # (_____) _____

Address _____

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any prescription medication? ☐ Yes ☐ No

If yes, please explain: _____

Are you taking any over the counter medication? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any allergies and/or allergies to any medications or substances? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any problems with antibiotics or anesthetics? ☐ Yes ☐ No

If yes, please explain: _____

Do you take appetite suppressants? ☐ Yes ☐ No

Name of product: _____

Please complete on reverse

THE DENTAL LAB

Dr. Karen Erani, DMD

MEDICAL HISTORY

Have you ever had any of the following diseases or medical conditions?

☐ Yes ☐ No	Heart Attack/Stroke	☐ Yes ☐ No	Epilepsy
☐ Yes ☐ No	Alcohol/Drug Abuse	☐ Yes ☐ No	Seizures
☐ Yes ☐ No	Cancer/Chemotherapy	☐ Yes ☐ No	Fainting
☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Tuberculosis
☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Hemophilia
☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Blood Transfusion
☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No	High Blood Pressure
☐ Yes ☐ No	Hepatitis C	☐ Yes ☐ No	Low Blood Pressure
☐ Yes ☐ No	Hepatitis D	☐ Yes ☐ No	Radiation Treatment
☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Kidney problems
☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Artificial Valves
☐ Yes ☐ No	Artificial Bones/Joints	☐ Yes ☐ No	Severe Headaches
☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No	Frequent Headaches
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Emphysema
☐ Yes ☐ No	Difficulty Breathing	☐ Yes ☐ No	Shingles
☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No	Heart Surgery
☐ Yes ☐ No	Herpes Type I	☐ Yes ☐ No	Pace Maker
☐ Yes ☐ No	Herpes Type II	☐ Yes ☐ No	Glaucoma
☐ Yes ☐ No	Psychiatric Problems	☐ Yes ☐ No	Do you consume alcohol?
☐ Yes ☐ No	Do you smoke?	☐ Yes ☐ No	Hip/knee replacement

Are you allergic to any of the following?

☐ Yes ☐ No	Penicillin	☐ Yes ☐ No	Codeine
☐ Yes ☐ No	Aspirin	☐ Yes ☐ No	Tetracycline
☐ Yes ☐ No	Erythromycin	☐ Yes ☐ No	Germicides/Pesticides
☐ Yes ☐ No	Latex/Rubber Products	☐ Yes ☐ No	Other

For Women Only:

☐ Yes ☐ No	Taking Birth Control Pills	☐ Yes ☐ No	Pregnant
☐ Yes ☐ No	Nursing?		# of Months ____
☐ Yes ☐ No	Hormone Therapy		

Signature _____ Date _____

618 Avenue O // Brooklyn, NY 11230 718/339/1111 www.TheDentalLabNY.com