Patient Name: _____ Date Of Birth: _____
Address/Zip_____
_____
Home Phone_____Cell Phone_____
Email Address: _____

Dr. Carole Thoman ~ Dr. Robin Thoman
doctor of dental surgery
DDS
paradox

Primary Care Physician: _____
Phone: ( ) _____
Address/Zip: _____

Please List **Additional Physicians** Below: Type of Specialty / Phone / Street Address / State / Zip

_____
_____
_____

Circle any of the following which you have had or have at present:

Heart Condition	Artificial Joint___ (date)	Thyroid Disease	Venereal Disease
Heart Attack or Stroke	Lung Disease	Glaucoma/ Cataracts	Herpetic Condition
Heart Murmur	Shortness of Breath	Arthritis / Rheumatism	Cold Sores
Chest Pains (Angina)	Tuberculosis	Pain in Jaw Joints	Acid Reflux or GERD
Artificial Heart Valves	Asthma or Hay Fever	Fainting or Dizzy Spells	Epilepsy or Seizures
Stent/Pacemaker	Skin Rashes or Hives	Alcoholism	Excessive Tiredness
High Blood Pressure	Kidney Trouble	Drug Addiction	Vision Loss L / R
Rheumatic Fever	Diabetes	Psychiatric Treatment	Sleep Apnea
Anemia	Sickle Cell Disease	AIDS	Loud Snoring
Prolonged Bleeding	Hepatitis _____A_____B	Cancer or Tumor	CPAP_____ OAT____
Swollen Ankles	Blood Transfusion	Radiation Therapy	Hearing Loss L / R

What kind of sports are you involved in? _____
_____
_____
_____
_____
_____
_____
_____

Do you have any health conditions or medical problems not listed above? *(If YES, please explain.)*
_____
_____
_____
_____

Are you now – or have you been treated by a physician in the past two years? *(If YES, please explain.)*
_____
_____
_____
_____

Are you presently taking any prescription medications, drugs, supplements, vitamins, minerals or over the counter medications including aspirin, birth control pills, etc?
(If YES, please list name, dosage, frequency and reason for medication.)

MEDICATION_____DOSE (mg) ___FREQUENCY____REASON_____
_____
_____
_____
_____
_____
_____
_____

Do you smoke or use smokeless tobacco?

☐ **Yes** ☐ **No** ☐ **Quit**

Are you allergic or sensitive to any medication, drug or other substance? *(If YES, please list each one.)*
_____
_____
_____
_____
_____
_____

Have you ever been hospitalized or had surgery?
(If YES, please explain.)
_____
_____
_____
_____
_____

Have you ever had complications or illness following a dental procedure? *(If YES, please explain.)*
_____
_____
_____
_____

HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH?

☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

WOMEN: ARE YOU PREGNANT NOW?

☐ **Yes** ☐ **No**

I understand that the information I provide on this form is essential to determine health needs and provide quality, safe dental treatment. I have answered truthfully and to the best of my ability. I will discuss any questions or changes in my health concerns with Dr. Thoman as soon as they arise.

Patient/Guardian Signature ***Date***

If any changes in your medical condition or history has occurred since you first completed this Medical History Form (or since you last updated it), please note these changes and sign your name. Include any changes in medication, hospitalization or illnesses. If no changes, please write "No Change" and sign or initial. Thank you.

DATE	CHANGES AND COMMENTS	SIGNATURE