CHARLES STRICK,DDS
20 Center Street, Ardsley, NY 10502
MEDICAL-DENTAL HISTORY

Name:____________________E-Mail____________________

Date of Birth:____________________SSN:____________________

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.
*Write the answer to each question in the space provided. Answer all questions.
* If the question is not understood, you are not certain of the answer or have any questions, indicate so in the space and discuss the matter with the doctor.

MEDICAL HISTORY

Name of Physician____________________Phone:____________________
Address:____________________
Date of last Visit: ____________________Reason for last visit:____________________

1. Are you currently under the care of a physician? If yes, for what reason or condition?__________
____
2. Are you currently taking any medication? If yes, what medication and for what reason or condition?____________________

HAVE YOU EVER BEEN TREATED FOR:

3. Rheumatic Fever, Rheumatic Heart Disease, Heart Murmur, or Heart Disease?__________
4. Heart Trouble, Heart Attack, Angina, Heart Surgery, a Pacemaker or Irregular Beats?__________
5. Stomach or Intestinal Disease?____________________
6. Abnormal Blood Pressure, Excessive Bleeding or Anemia?____________________
7. Breathing Problems, Asthma, Tuberculosis or Hay Fever?____________________
8. Cancer, X-Ray Treatments or Chemotherapy?____________________
9. Diabetes?____________________
10. Hepatitis, Jaundice or Liver Disease?____________________
11. Kidney Problems or Renal Dialysis? ____________________
12. Venereal Disease, AIDS or HIV+?____________________
13. A Stroke, Convulsions or Fainting Spells?____________________
14. Tumors or Growths?____________________
15. Arthritis or Rheumatism?____________________
16. Allergic Reactions to Medications?____________________
17. Have you ever had a major operation? If yes, Describe____________________
18. Have you ever had a serious injury to your head or neck? If yes, describe____________________
19. Are you on a special diet? If yes, for what reason and describe____________________
20. Have you ever had a joint replacement surgery? If yes, Date of surgery and specify joint________
Any complications related to the joint prosthesis?____________________
21. Are there any other problems about your health of which you are aware of?____________________
22. For Women: Are you pregnant? Are you taking Birth Control Pills?________________

SOME ANTIBIOTICS USED IN DENTISTRY MAY DECREASE THE EFFECTIVENESS OF BIRTH CONTROL PILLS.