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3 YEAR MEDICAL HISTORY UPDATE

- | | |
|--|--------|
| 1. Are you having any pain or discomfort at this time? | Yes No |
| 2. Do you or have you ever needed pre-medication before dental procedures? | Yes No |
| 3. Have you been hospitalized within the last 3 years? | Yes No |
| 4. Are you under the care of a physician for a specific reason? | Yes No |
| 5. Are you taking any medications or drugs now? | Yes No |
| 6. Are you aware of being allergic to any medications or substance? | Yes No |
| 7. Have you reacted adversely to any medications or substance? | Yes No |

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

- | | | | |
|---------------------------------------|---------------------|---------------------------|------------------------|
| Heart Failure | Stroke | Emphysema | AIDS/HIV |
| Heart Disease | Heart Attack | Hepatitis A (infectious) | Kidney Trouble |
| Angina Pectoris | Cough | Hepatitis B (serum) | Ulcers |
| High Blood Pressure | Tuberculosis (TB) | Liver Disease | Cosmetic Surgery |
| Heart Murmur | Asthma | Arthritis | Lupus |
| Yellow Jaundice | Anemia | Blood Transfusion | Pain In Jaw Joints |
| Rheumatic Fever | Sinus Trouble | Psychiatric Treatment | Diabetes |
| Allergies or Hives | Drug Addiction | Heart Pacemaker | Thyroid Disease |
| Hemophilia | Sickle Cell Disease | X-Ray or Cobalt Treatment | Chemotherapy |
| Bruise easily | Heart Surgery | Epilepsy or Seizures | Cancer |
| Mitral Valve Prolapse (MVP) | Rheumatism | Fainting or Dizzy Spells | Nervousness |
| Artificial joints (Knee, Hip, Etc...) | | Hay fever | Glaucoma |
| Cold Sores | Congenital Heart | Scarlet Fever | Artificial Heart Valve |
| Venereal Disease | Fever Blisters | Latex Allergy | |

For Women Only

- Are you pregnant? Yes No
 If yes, how many months? _____
 Are you taking birth control medication? Yes No

I confirm the above information is true.

Patient Signature _____ *Date* _____