DNA DENTAL
DALLAS

MEDICAL HISTORY

DNA Dental Dallas, Dr. Darya Timin
6162 East Mockingbird Lane., Suite 205 Dallas, TX 75214
214-295-9270 | www.dnadentaldallas.com

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you currently under the active care of a physician? If so, please list Doctor's Name and Phone number? ☐ Yes ☐ No
If Yes: Physician Name: _____ Phone Number: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No
If Yes: _____

Do you need to be pre-medicated with antibiotics for any heart or other conditions before dental treatment? ☐ Yes ☐ No
If Yes: _____

List all prescription and over-the-counter medications or supplements you are currently taking:

Women Are You:
Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No
If yes, which trimester? ☐ 1st ☐ 2nd ☐ 3rd

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa drugs	☐ LocalAnesthetic

Other: ☐ Yes ☐ No If Yes: _____

Do you have, or have you had, any of the following?

☐ Yes ☐ No AIDS/HIV Positive	☐ Yes ☐ No Cortisone Medicine	☐ Yes ☐ No Heart Surgery	☐ Yes ☐ No Radiation Treatments
☐ Yes ☐ No Alzheimer's Disease	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Hemophilia	☐ Yes ☐ No Recent Weight Loss
☐ Yes ☐ No Anaphylaxis	☐ Yes ☐ No Drug Addiction	☐ Yes ☐ No Hepatitis A	☐ Yes ☐ No Renal Dialysis
☐ Yes ☐ No Anemia	☐ Yes ☐ No Easily Winded	☐ Yes ☐ No Hepatitis B or C	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Angina	☐ Yes ☐ No Emphysema	☐ Yes ☐ No Herpes	☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Arthritis/Gout	☐ Yes ☐ No Epilepsy or Seizures	☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Shingles
☐ Yes ☐ No Artificial Heart Valve	☐ Yes ☐ No Excessive Bleeding	☐ Yes ☐ No High Cholesterol	☐ Yes ☐ No Sickle Cell Disease
☐ Yes ☐ No Artificial Joint	☐ Yes ☐ No Excessive Thirst	☐ Yes ☐ No Hives/Rash	☐ Yes ☐ No Sinus Trouble
☐ Yes ☐ No Asthma	☐ Yes ☐ No Fainting/Dizziness	☐ Yes ☐ No Hypoglycemia	☐ Yes ☐ No Spinal Bifida
☐ Yes ☐ No Blood Disease	☐ Yes ☐ No Frequent Cough	☐ Yes ☐ No Irregular Heartbeat	☐ Yes ☐ No Stomach/Intestinal Disease
☐ Yes ☐ No Blood Transfusion	☐ Yes ☐ No Frequent Diarrhea	☐ Yes ☐ No Kidney Problems	☐ Yes ☐ No Stroke
☐ Yes ☐ No Breathing problems	☐ Yes ☐ No Frequent Headaches	☐ Yes ☐ No Leukemia	☐ Yes ☐ No Swelling of Limbs
☐ Yes ☐ No Bruise Easily	☐ Yes ☐ No Genital Herpes	☐ Yes ☐ No Liver Disease	☐ Yes ☐ No Thyroid Disease
☐ Yes ☐ No Cancer	☐ Yes ☐ No Glaucoma	☐ Yes ☐ No Low Blood Pressure	☐ Yes ☐ No Tonsillitis
☐ Yes ☐ No Chemotherapy	☐ Yes ☐ No Hay Fever	☐ Yes ☐ No Lung Disease	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Chest Pains	☐ Yes ☐ No Heart Attack/Failure	☐ Yes ☐ No Mitral Valve Prolapse	☐ Yes ☐ No Tumors or Growths
☐ Yes ☐ No Cold Sores/Fever Blisters	☐ Yes ☐ No Heart Murmur	☐ Yes ☐ No Osteoporosis	☐ Yes ☐ No Ulcers
☐ Yes ☐ No Congenital Heart Disorder	☐ Yes ☐ No Hear Pacemaker	☐ Yes ☐ No Pain in Jaw Joints	☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No Convulsions	☐ Yes ☐ No Heart Trouble/ Disease	☐ Yes ☐ No PParathyroid Disease	
☐ Yes ☐ No Yellow Jaundicce		☐ Yes ☐ No Psychiatric Care	

Please list any serious illnesses not listed above: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understandthat providing incorrect information can be dangerous to my (or patent's) health.

Signature _____ Date _____