New Britain Dental Arts

NAME:_____ **AGE:** _____ ❑ Male ❑ Female

Do you have a cardiologist? Yes or No Who:_____

Name of your primary care physician_____

REVIEW OF SYSTEMS: (Check any of the following that you've had in the last year)

❑ Weight loss	❑ Chest pain	❑ Muscle weakness
❑ Weight gain	❑ Irregular heart beat	❑ Rashes
❑ Fatigue	❑ Shortness of breath	❑ Sores
❑ Blurry Vision	❑ Trouble breathing	❑ Numbness
❑ Double Vision	❑ Cough	❑ Poor balance
❑ Ringing in ears	❑ Upset stomach	❑ Anxiety
❑ Hearing Loss	❑ Diarrhea	❑ Depression
❑ Sinus Congestion	❑ Bloody stools	❑ Hair loss
❑ Bloody nose	❑ Frequent urination	❑ Excessive thirst
❑ Loss of taste	❑ Burning with urination	❑ Easy bruising
❑ Dry mouth	❑ Joint pain	❑ Food allergies
❑ Sore throat	❑ Joint stiffness	❑ Seasonal allergies

NONE OF THE ABOVE PLEASE MARK HERE_____**(none)**

PAST MEDICAL HISTORY:

Ulcers	**Yes or No**
Diabetes	**Yes or No**
Heart Disease	**Yes or No**
Circulation Problems	**Yes or No**
High Blood Pressure	**Yes or No**
Cancer	**Yes or No**
Lung Disease	**Yes or No**
Hepatitis	**Yes or No**
HIV	**Yes or No**

Other_____

Previous Surgery(s)

1_____

2_____

3_____

4_____

Allergies

1_____

2_____

Medications:(List Dose and How Often)

(Include Over-the-Counter & Holistic Medicines)

1_____

2_____

3_____

4_____

5_____

6_____

7_____

8_____

9_____

10 _____

11_____