O'LEARY DENTAL OFFICE

Kevin S. O'Leary, D.D.S.

MEDICAL HISTORY NEW PATIENT EVALUATION

PATIENT'S NAME: _____ **DOB:** _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? YES / NO

If yes, please explain: _____

Name of Treating Physician: _____

CoVid -19

Are you experiencing a fever?	**YES / NO**
Are you feeling well other than your dental emergency?	**YES / NO**
Do you have symptoms of cough?	**YES / NO**

LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

_____ _____
_____ _____
_____ _____
_____ _____

LIST VITAMINS / SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING:

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES TO MEDICATIONS:

_____ _____
_____ _____
_____ _____

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CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

A.I.D.S. / A.R.C. / HIV	Epilepsy / Seizures	Neurological Disorder
Alcoholism	Fainting / Dizziness	Psychiatric / Mental Health Issues
Allergic Reactions (medications)	Fever Blisters	Pain in Jaw Joints
Anemia	Glaucoma	Radiation Therapy
Angina Pectoris	Heart Disease or Attack	Rheumatic Fever
Artificial Heart Value	Heart Murmur	Shortness of Breath / COPD
Artificial joints / hips / knees	Heart Pacemaker	Sickle Cell
Arthritis / Rheumatism	Hemophilia	Sinus Trouble
Asthma / Hay fever / Allergies	Hepatitis A / B / C	Stroke
Blood transfusions	High / Low Blood Pressure	Swelling / Edema
Bruise Easily	Liver Disease	Tonsil / Adenoid Problems
Chemotherapy	Jaundice	Thyroid Disease
Diabetes	Kidney Problems	Tuberculosis
Drug addictions	Mitral Valve Prolapse	Ulcers
Emphysema	Nervousness / Anxiety	Veneral Disease

Please write in any other pertinent information that may not have been covered in the above areas:

_____

_____

AUTHORIZATION: I hereby authorize Dr. O'Leary and / or his dental staff to administer, diagnostic tests and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The medical history and information provided is given to the best of my knowledge. I also authorize the doctor and/or dental staff to contact my healthcare providers concerning my treatment as necessary.

X_____ _____

Patient Signature or Guardian's Signature **Date**

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