Victor Immel, DMD, PS

Medical History

Your current physical health? Good Fair Poor **Are you currently under a physician's care?**

Explain:____

Name of primary physician________________________**Phone**____________________________

Date of last physical:_____________**Are you currently taking any prescription/over-the-counter drugs?**

Please list drugs and reason____

Have you ever had any of the following?

Yes No Heart Attack

Yes No Stroke

Yes_____No______ Heart Surgery

Yes_____No______ Pacemaker

Yes_____No______Artificial Joints

Yes_____No______ Artificial Valves

Yes_____No______ HIV/Aids

Yes_____No______ High Blood Pressure

Yes_____No______ Low Blood Pressure

Yes_____No______ Sinus Problems

Yes_____No______ Drug/Alcohol Use

Yes_____No______Mitral Valve Prolapse

Yes_____No______Blood Clots

Yes_____No______Pulmonary Embolism

Yes_____No______ Diabetes

Yes_____No______ Asthma

Yes_____No______ Hepatitis A

Yes_____No______ Hepatitis B

Yes_____No______ Ulcers

Yes_____No______ Cancer Therapy

Yes_____No______ Headaches

Yes_____No______ Use Tobacco Products

If yes, for how many years?________

Please list any serious medical condition(s) that you have ever had:____________________

____

Are you allergic to any of the following drugs?

Yes_____No______ Penicillin Yes_____No______ Aspirin Yes_____No______ Sulfa

Yes_____No______ Erythromycin Yes _____No______Dental Anesthetics Yes_____No _____ Latex

Yes_____No______Tetracycline Yes_____No______Codeine

Yes_____No______Other

Please list any foods or drugs to which you are allergic:_______________________________