Hilliard Advanced Dentistry
Healthy Smiles for a Lifetime

Neeru Sharma DDS, MS
Cosmetic, Implant & General Dentistry

5132 Norwich Street, Hilliard, OH 43026
Phone (614) 876-8766 Fax (614) 876-8804
www.HilliardAdvancedDentistry.com

Medical History

Patient Information

Patient Name:_____Date_____
Last First M.I. (Preferred Name)

Have you ever had the following? Please check all that apply:

[ ] AIDS or HIV	[ ] Fainting	[ ] Liver Disease	[ ] Stroke
[ ] Allergies	[ ] Glaucoma	[ ] Mental disorders	[ ] Thyroid Disease
[ ] Anemia	[ ] Growths	[ ] Nervous Disorders	[ ] Tuberculosis
[ ] Artificial Heart Valve	[ ] Hay Fever	[ ] Pacemaker	[ ] Tumors
[ ] Arthritis	[ ] Head Injuries	[ ] Mitral Valve Prolapse	[ ] Ulcers
[ ] Artificial Joints	[ ] Heart Disease	[ ] Nursing	[ ] Venereal Herpes
[ ] Asthma	[ ] Heart Murmur	[ ] Pregnancy	[ ] Codeine Allergy
[ ] Blood Disease	[ ] Hepatitis A	[ ] Radiation Treatment	[ ] Penicillin Allergy
[ ] Cancer	[ ] Hepatitis B	[ ] Respiratory Problems	[ ] Latex sensitivity
[ ] Diabetes	[ ] Hepatitis C	[ ] Rheumatic Fever	[ ] Radiation
[ ] Dizziness	[ ] High Blood Pressure	[ ] Rheumatism	[ ] Chemotherapy
[ ] Epilepsy	[ ] Jaundice	[ ] Sinus Problems	[ ] OTHER:_____
[ ] Excessive Bleeding	[ ] Kidney Disease	[ ] Stomach Problems	

Have you ever had any complications following dental treatment? [ ] Yes [ ] No

If yes, please explain: _____

Have you been admitted to a hospital or for emergency care during the past two years? [ ] Yes [ ] No

If yes, please explain: _____

Are you now under the care of a physician? [ ] Yes [ ] No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? [ ] Yes [ ] No

If yes, please explain: _____

Current Medications:

_____

_____

Adverse reactions to medications in the past: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor before the next appointment.

Patient/guardian Signature _____ **Date** _____

Patient's Name (printed) _____

Dentist Signature _____ **Date** _____