DR. GREGORY YOUNT
MATTOON DENTAL

Medical History

Physician's Name_____ Phone_____

Date of last visit_____ Have you had any serious illnesses or operations? ☐Y ☐N

If yes, please describe_____

Are you currently under physician care? ☐Y ☐N If yes, describe_____

Have you ever had a blood transfusion? ☐Y ☐N If yes, give dates_____

Have you ever taken Fen-Phen/Redux? ☐Y ☐N

Women: Are you Pregnant: ☐Y ☐N Nursing? ☐Y ☐N Taking birth control? ☐Y ☐N

Check (☐) Yes or No whether you have had any of the following: (please fill out completely)

☐Y ☐N AIDS/HIV Positive	☐Y ☐N Cough, Persistent	☐Y ☐N Jaw pain	☐Y ☐N Shingles
☐Y ☐N Anaphylaxis	☐Y ☐N Cough up Blood	☐Y ☐N Kidney disease	☐Y ☐N Shortness of breath
☐Y ☐N Anemia	☐Y ☐N Diabetes	☐Y ☐N Liver Disease	☐Y ☐N Skin rash
☐Y ☐N Arthritis, Rheumatism	☐Y ☐N Epilepsy	☐Y ☐N Material Allergies	☐Y ☐N Spina Bifida
☐Y ☐N Artificial Heart Valves	☐Y ☐N Fainting	☐Y ☐N Mitral valve prolapse	☐Y ☐N Stroke
☐Y ☐N Artificial Joints	☐Y ☐N Food allergies	☐Y ☐N Nervous problems	☐Y ☐N Surgical implant
☐Y ☐N Asthma	☐Y ☐N Glaucoma	☐Y ☐N Pacemaker/Heart Surgery	☐Y ☐N Swelling of feet / ankles
☐Y ☐N Atopic (allergy prone)	☐Y ☐N Headaches	☐Y ☐N Psychiatric Care	☐Y ☐N Thyroid Disease
☐Y ☐N Back problems	☐Y ☐N Heart murmur	☐Y ☐N Rapid Weight gain or loss	☐Y ☐N Tobacco Habit
☐Y ☐N Blood disease	☐Y ☐N Heart Problems*	☐Y ☐N Radiation Treatment	☐Y ☐N Tonsillitis
☐Y ☐N Cancer*	☐Y ☐N Hemophilia / Bleeding	☐Y ☐N Respiratory disease	☐Y ☐N Tuberculosis
☐Y ☐N Chemical dependency	☐Y ☐N Herpes	☐Y ☐N Rheumatic / Scarlet fever	☐Y ☐N Ulcer / Colitis
☐Y ☐N Chemotherapy	☐Y ☐N Hepatitis	☐Y ☐N Venereal disease	☐Y ☐N Circulatory problems
☐Y ☐N Cortisone Treatments	☐Y ☐N High Blood Pressure		

Is patient currently taking any medications? Does patient have drug allergies? If yes, please list all:

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