

Medical History

Patient Name: _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- | | | | |
|---|---|--|--|
| ☐ *Pre-Med - Amox | ☐ *Pre-Med - Clind | ☐ *Pre-Med - Other | ☐ AIDS/HIV Positive |
| ☐ Allergy-Acrylic | ☐ Allergy-Aspirin | ☐ Allergy-Codeine | ☐ Allergy-Ibuprofen |
| ☐ Allergy-Latex | ☐ Allergy-Metal | ☐ Allergy-Other | ☐ Allergy-Penicillin |
| ☐ Allergy-Pollen | ☐ Allergy-Sulfa Drugs | ☐ Allergy-Tylenol | ☐ Allergy-Anesthetics |
| ☐ Alzheimer's Disease | ☐ Anaphylaxis | ☐ Anemia | ☐ Angina |
| ☐ Anxiety disorder | ☐ Arthritis/Gout | ☐ Artificial H.V | ☐ Artificial Joints |
| ☐ Asthma | ☐ Back problems | ☐ Blood Disease | ☐ Blood Transfusion |
| ☐ Breathing Problem | ☐ Cancer | ☐ Cerebral Palsy | ☐ Chemotherapy |
| ☐ Chest Pains | ☐ Cold Sores | ☐ Convulsions | ☐ Depression |
| ☐ Diabetes | ☐ Dizziness | ☐ Drug Addiction | ☐ Emphysema |
| ☐ Epilepsy Or Seizures | ☐ Excessive Bleeding | ☐ Excessive Thirst | ☐ Fainting |
| ☐ Frequent Cough | ☐ Genital Herpes | ☐ Glaucoma | ☐ Hay Fever |
| ☐ Head Injuries | ☐ Headaches | ☐ Heart Disease | ☐ Heart Murmur |
| ☐ Heart Pacemaker | ☐ Heart problems | ☐ Heartburn | ☐ Hepatitis |
| ☐ Hepatitis A | ☐ Hepatitis B or C | ☐ Herpes | ☐ High Blood Pressure |
| ☐ High Cholesterol | ☐ Hypoglycemia | ☐ Jaundice | ☐ Jaw Pain |
| ☐ Kidney problems | ☐ Knee Surgery | ☐ Leukemia | ☐ Liver Disease |
| ☐ MVP | ☐ Mental Disorders | ☐ Nervous Disorders | ☐ No Percocet |
| ☐ No Sulfa | ☐ Osteoporosis | ☐ Other | ☐ Parathyroid Disease |
| ☐ Polycyclic ovarian cys | ☐ Pregnant/Nursing | ☐ Psychiatric Care | ☐ Radiation Treatment |
| ☐ Renal Dialysis | ☐ Respiratory Problems | ☐ Rheumatic Fever | ☐ Rheumatism |
| ☐ STD/HPV | ☐ Scarlet Fever | ☐ Scoliosis | ☐ Sickle Cell Disease |
| ☐ Sinus Problems | ☐ Smoking | ☐ Stomach Problems | ☐ Stroke |
| ☐ Thyroid Disease | ☐ Tonsillitis | ☐ Tuberculosis | ☐ Tumors |
| ☐ Ulcers | | | |

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

Allergies not listed:

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ☐ Yes ☐ No

Pre-Med:

Name of your Physician and Phone Number:

Preferred Pharmacy, Location, and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

☐ Yes ☐ No

Please list any medications you are currently taking, one medication per line:

☐ * By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Response Date: _____