Medical History

Patient Name: [ ] Last [ ] First [ ] M/ [ ] 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
- ADD/ADHD
- AIDS/HIV
- Allergy - Amoxicilli
- Allergy - Aspirin
- Allergy - Cipro
- Allergy - Codeine
- Allergy - Demerol
- Allergy - Erythro
- Allergy - Hay Fever
- Allergy - Hydrocodon
- Allergy - Iodine
- Allergy - Latex
- Allergy - List Other
- Allergy - Peanuts
- Allergy - Penicillin
- Allergy - Sulta
- Allergy - Vencomycin
- Allergy - Vibramycin
- Anemia
- Arthritis
- Artificial Joint/Lim
- Asthma
- Autism
- Blood Disease
- Blood Pressure-High
- Blood Pressure-Low
- Bisphosphonates
- Cancer/Chemotherapy
- Cold Sores/Herpes
- Diabetes
- Dizziness/Fainting
- Epilepsy/Seizure
- Excessive Bleeding
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis
- Jaundice
- Kidney Disease
- Liver Disease
- Lupus
- Mental Disorders
- Nervous Disorders
- Osteopenia
- Osteoporosis
- Pacemaker
- Pregnancy
- Radiation Treatment
- Recreational Drugs
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Smoker
- Stomach Problems
- Stroke
- Thyroid
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease

- Ever been hospitalized (illness or injury)
- Presently being treated for any other illnesses
- Subject to frequent headaches
- Tobacco/Alcohol Use
- FEMALE: Taking birth control pills
- FEMALE: Pregnant
If any conditions or alerts selected above need further clarification, please describe below:


Do you take antibiotic premedication for your dental visits? If yes, please explain the reason and dosage.


What is your estimate of your general health?

☐ Excellent  ☐ Good  ☐ Fair  ☐ Poor

Name of your physician and phone number:


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


List all medications (prescription and non-prescription) including regular doses of aspirin:


Do you have any medication allergies? If yes, please list.


☐ 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.

Office Use Only:


