



## 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.

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> *Pre-Med - Amox      | <input type="checkbox"/> *Pre-Med - Clind     | <input type="checkbox"/> *Pre-Med - Other    | <input type="checkbox"/> ADD/ADHD             |
| <input type="checkbox"/> AIDS/HIV             | <input type="checkbox"/> Allergy - Amoxicilli | <input type="checkbox"/> Allergy - Aspirin   | <input type="checkbox"/> Allergy - Cipro      |
| <input type="checkbox"/> Allergy - Codeine    | <input type="checkbox"/> Allergy - Demerol    | <input type="checkbox"/> Allergy - Erythro   | <input type="checkbox"/> Allergy - Hay Fever  |
| <input type="checkbox"/> Allergy - Hydrocodon | <input type="checkbox"/> Allergy - Iodine     | <input type="checkbox"/> Allergy - Latex     | <input type="checkbox"/> Allergy - List Other |
| <input type="checkbox"/> Allergy - Peanuts    | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa     | <input type="checkbox"/> Allergy - Vencomycin |
| <input type="checkbox"/> Allergy - Vibramycin | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Artificial Joint/Lim |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Autism               | <input type="checkbox"/> Bisphosphonates     | <input type="checkbox"/> Blood Disease        |
| <input type="checkbox"/> Blood Pressure-High  | <input type="checkbox"/> Blood Pressure-Low   | <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Cold Sores/Herpes    |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Dizziness/Fainting   | <input type="checkbox"/> Epilepsy/Seizure    | <input type="checkbox"/> Excessive Bleeding   |
| <input type="checkbox"/> Head Injuries        | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Lupus                |
| <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Osteopenia          | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Recreational Drugs   |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Rheumatism          | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Smoker               | <input type="checkbox"/> Stomach Problems     | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Thyroid              |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Tumors               | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Venereal Disease     |

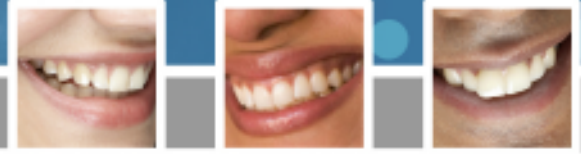
- |   |  |
|---|--|
| <input type="checkbox"/> Ever been hospitalized (illness or injury) | <input type="checkbox"/> Presently being treated for any other illnesses |
| <input type="checkbox"/> Subject to frequent headaches              | <input type="checkbox"/> Tobacco/Alcohol Use                             |
| <input type="checkbox"/> FEMALE: Taking birth control pills         | <input type="checkbox"/> FEMALE: Pregnant                                |

# Logos Dentistry

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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:

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Response Date: