Logos Dentistry
3195 W. Ray Road, Suite 3
Chandler, AZ 85226-2417

(480)788-3627
frontdesk@logosdentistry.com
www.logosdentistry.com

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
- ☐ 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 - Sulfa
- ☐ Allergy - Vencomycin
- ☐ Allergy - Vibramycin
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint/Lim
- ☐ Asthma
- ☐ Autism
- ☐ Bisphosphonates
- ☐ Blood Disease
- ☐ Blood Pressure-High
- ☐ Blood Pressure-Low
- ☐ 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

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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: