

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 | ☐ AMOXICILLIN | ☐ Anemia | ☐ Arthritis |
| ☐ Artificial Joint/Lim | ☐ Asthma | ☐ Autism | ☐ Bisphosphonates |
| ☐ Blood Disease | ☐ Blood Pressure H/L | ☐ Cancer/Chemotherapy | ☐ CODEINE |
| ☐ Cold Sores/Herpes | ☐ Diabetes | ☐ Dizziness/Fainting | ☐ Epilepsy/Seizure |
| ☐ Epinephrine | ☐ Excessive Bleeding | ☐ Head Injuries | ☐ Heart Disease |
| ☐ Heart Murmur | ☐ Hepatitis | ☐ IBUPROFEN | ☐ Jaundice |
| ☐ Kidney Disease | ☐ Liver Disease | ☐ Lupus | ☐ Mental Disorders |
| ☐ Nervous Disorders | ☐ Osteopenia | ☐ Osteoporosis | ☐ Other |
| ☐ Other Allergies Note | ☐ 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:

Response Date: _____