

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"/> NO Epinephrine | <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergy | <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Clindamycin |
| <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever | <input type="checkbox"/> Allergy - Kleenex |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa |
| <input type="checkbox"/> Allergy to Fluoride | <input type="checkbox"/> Allergy to-Zithromax | <input type="checkbox"/> Alzheimers Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Congenital Heart Dis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Crohns | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Doxycycline | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fluoride | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> MINT |
| <input type="checkbox"/> MRSA | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Mitral Valve Prolaps | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Prednisone | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> RED DYE | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> See Patient Notes | <input type="checkbox"/> Septocaine | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Thimerisol | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Vision impaired |
| <input type="checkbox"/> add | <input type="checkbox"/> add1 | <input type="checkbox"/> allergy to PCN | <input type="checkbox"/> propylene glycol |

- | | | |
|---|--|--|
| <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 |

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.

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:

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.

Response Date: _____