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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.

- ☐ *Premed
- ☐ ALLERGIES
- ☐ Allergy Codeine
- ☐ Anti-Coagulant Drug
- ☐ ARTHRITIS
- ☐ Autoimmune Disorder
- ☐ Cat Dander
- ☐ Cholesterol Med
- ☐ Depression/Anxiety
- ☐ Epilepsy
- ☐ Flagil
- ☐ Hay Fever
- ☐ Hepatitis
- ☐ Hormone Therapy
- ☐ Latex Allergy
- ☐ Lortab
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ See Chart
- ☐ STD
- ☐ Sulfa
- ☐ Tumors
- ☐ Acid Reflux
- ☐ Allergy Amoxil
- ☐ Allergy Fluoride
- ☐ ANXIETY
- ☐ Artificial Joints
- ☐ BI-POLAR DISORDER
- ☐ Cephalexin
- ☐ CODEINE
- ☐ Diabetes
- ☐ Erythromycin
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ IV BISPHOSPHONATES
- ☐ LATEX ALLERGY
- ☐ Mental Disorders
- ☐ NO STEROIDS
- ☐ Pacemaker
- ☐ PSYCHOLOGICAL CARE
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Thyroid Problems
- ☐ Ulcerative Colitis
- ☐ Acid Reflux
- ☐ Allergy Bactrim
- ☐ Allergy Penicillin
- ☐ ANXIETY
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cephalexin/
- ☐ Codeine Allergy
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Growths
- ☐ Heart Disease
- ☐ HIV
- ☐ Jaundice
- ☐ legally blind
- ☐ Mold
- ☐ NSAIDS
- ☐ Parkinson's Disease
- ☐ Radiation Treatment
- ☐ Rosemary Oil
- ☐ Sjorgrens Syndrome
- ☐ Stroke
- ☐ thyroidectomy
- ☐ Ulcers
- ☐ Allergies
- ☐ Allergy Cipro
- ☐ Anemia
- ☐ Arthritis
- ☐ AUGMENTIN
- ☐ Cancer
- ☐ Chlorexidine
- ☐ DEMENTIA
- ☐ Emphysema
- ☐ Fainting
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ peanut/ nuts
- ☐ Respiratory Problems
- ☐ Seasonal
- ☐ Smoker
- ☐ Sulfa
- ☐ Tuberculosis
- ☐ Vitamins

☐ Tobacco use ☐ Vapor use ☐ Recreational drug use

Woman only

☐ Currently pregnant ☐ Nursing ☐ Taking birth control

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____

_____

_____

_____

Do you own a C- pap machine? * ◯ Yes ◯ No

Have you been told you snore? * ◯ Yes ◯ No

Have you had a sleep study in a clinic? * ◯ Yes ◯ No

Do you want Nitrious at your dental visit? * ◯ Yes ◯ No

Allergies not listed:

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

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

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

☐ * **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.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-_____ (Zip Code)