

### 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.

- \*NO Pre-Med
- Allergy: Amoxicillin
- Allergy: Augmentin
- Allergy: Cipro
- Allergy: Garlic
- Allergy: Ibuprophen
- Allergy: Morphine
- Allergy: Penicillin
- Allergy: Seafood
- Allergy: Toradol
- Allergy: Tetracycline
- Arthritis
- Cancer
- Drug Abuse
- Head Injuries
- Heart Murmur
- Kidney Disease
- Osteoprosis
- Radiation Treatment
- Seizures
- Stroke
- Tumors
- \*No Epi
- Allergy: Anesthetic
- Allergy: Bactrim
- Allergy: Dilaudid
- Allergy: Gluten
- Allergy: Iodine
- Allergy: Naprosyn
- Allergy: Relafen
- Allergy: Seasonal
- Allergy: Zithromycin
- Allergy; Neurotin
- Artificial Joints
- Crohn's Diease
- Epilepsy
- Headaches/Migraines
- Heart Problems
- Liver Disease
- Pacemaker
- Respiratory Problems
- Sinus Problems
- Thyroid Problems
- Ulcers
- \*Pre-Med
- Allergy: Antibiotic
- Allergy: Biaxin
- Allergy: Doxycycline
- Allergy: Hydrocodone
- Allergy: Latex
- Allergy: Oxycodone
- Allergy: Requip
- Allergy: Steriod
- Allergy: codiene
- Alzheimer Disease
- Asthma
- Dementia
- Glaucoma
- Hearing Problems
- Hepatitis / Jaundice
- MVP
- Parkinson's Disease
- Rheumatic Fever
- Sjogren Syndrome
- Tobacco/Vapor Use
- Whooping Cough
- Allergy: Ambien
- Allergy: Aspirin
- Allergy: Ceclor
- Allergy: Eliquis
- Allergy: Hydroxyzine
- Allergy: Milk
- Allergy: Pain Med
- Allergy: SACC
- Allergy: Sulfa
- Allergy:Erythromycin
- Anemia
- COPD
- Diabetes
- HIV / Aids
- Heart Attack
- High Blood Pressure
- Mental/Nervous Dis
- Pregnant / Nursing
- STD
- Stomach Problems
- Tuberculosis

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

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.

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Patient's 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