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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
- ☐ Allergy Epi
- ☐ Allergy Codeine
- ☐ Allergy Metal
- ☐ Allergy Percocet/dan
- ☐ Allergy Tetracycline
- ☐ Allergy to Prilosec
- ☐ Artificial Joints
- ☐ Blood Thinners
- ☐ Depression
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Jaw Pain
- ☐ Mental Disorders
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Tumors/Growths
- ☐ Acid Reflux
- ☐ Allergy Amox
- ☐ Allergy Erythromycin
- ☐ Allergy Morphine
- ☐ Allergy Seasonal
- ☐ Allergy to Augmentin
- ☐ Alzheimers/Dementia
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Headaches/Migraines
- ☐ Herpes
- ☐ Hyper-Thyroid
- ☐ Kidney Disease
- ☐ Mitral Valve Prolaps
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Ulcers
- ☐ Alcoholism
- ☐ Allergy Ampicillin
- ☐ Allergy Iodine
- ☐ Allergy Peanuts
- ☐ Allergy Shellfish
- ☐ Allergy to Biaxin XL
- ☐ Anemia
- ☐ Bi-polar
- ☐ Chemo / Radiation
- ☐ Dizziness/Fainting
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hypo-Thyroid
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Sinus Problems
- ☐ TMJ
- ☐ xOther Explain Below
- ☐ Allergies -See Notes
- ☐ Allergy Clindamycin
- ☐ Allergy Latex
- ☐ Allergy Penicillin
- ☐ Allergy Sulfa
- ☐ Allergy to Ibuprofen
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Dementia
- ☐ Emphysema
- ☐ Hashimoto's Disease
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Lyme Disease
- ☐ Pacemaker
- ☐ STD / HPV
- ☐ Tuberculosis

☐ Subject to frequent headaches ☐ FEMALE: Pregnant or Planning Pregnancy ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification, please describe below (including due date if pregnant):

_____

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you use alcohol? If so, how frequently?

☐ Don't use ☐ Daily ☐ Weekly ☐ Rarely

Do you use nicotine? If so, how or what form? *

☐ Don't Use ☐ Smoking ☐ Chewing ☐ Vaping

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

PRE-MED

Are you taking any medications (prescription and non-prescription) including regular doses of aspirin or birth control pills? If yes, please list below. *

◯ Yes ◯ No

MEDICATIONS

Have you taken or are you taking any Bisphosphonate drug used to treat osteoporosis or Paget's disease? Examples; Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa etc. If yes, please list the drug and date taken. *

◯ Yes ◯ No

BISPHOSPHONATES

Do you have any allergies (including allergies to medications)? If yes, please explain below * ◯ Yes ◯ No

ALLERGIES

Name of your Physician and phone number: *

Name and phone number of preferred Pharmacy: *

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

☐ ***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.**

Response Date: _____