# Medical History (old)

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FAMILY DENTISTRY

Patients First Name *

Patients Last Name *

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.**

- [ ] Acid Reflux
- [ ] Allergy Amoxicillin
- [ ] Allergy Anesthetic
- [ ] Allergy Aspirin
- [ ] Allergy Azithromycin
- [ ] Allergy Clindamycin
- [ ] Allergy Codeine
- [ ] Allergy Erythomycin
- [ ] Allergy Fluoride
- [ ] Allergy Fruit
- [ ] Allergy Ibuprofen
- [ ] Allergy Iodine
- [ ] Allergy Latex
- [ ] Allergy Metals
- [ ] Allergy Milk
- [ ] Allergy Nuts
- [ ] Allergy Penicillin
- [ ] Allergy Red Dye
- [ ] Allergy Sulfa
- [ ] Allergy Tetracycline
- [ ] Allergy Tylenol
- [ ] Anemia
- [ ] Angina (Chest Pain)
- [ ] Arthritis
- [ ] Artificial Joint
- [ ] Artificial Valve
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Birth Control Use
- [ ] Bisphosphonate Use
- [ ] Bleeding Problems
- [ ] Blood Thinners
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chronic Pain
- [ ] Dementia
- [ ] Depression
- [ ] Diabetes Type 1
- [ ] Diabetes Type 2
- [ ] Eating Disorder
- [ ] Emphysema
- [ ] Endocarditis
- [ ] Epilepsy
- [ ] Fainting Spells
- [ ] Glaucoma
- [ ] Hearing Problems
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Failure
- [ ] Heart Valve Problem
- [ ] Hepatitis C
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] Illicit Drug Use
- [ ] Jaundice
- [ ] Kidney Problems
- [ ] Learning Disorder
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Multiple Sclerosis
- [ ] Nursing Child
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Psychiatric Disorder
- [ ] Radiation Treatment
- [ ] Seizures
- [ ] Sinus Problems
- [ ] Sjogrens
- [ ] Sleep Problems
- [ ] Stomach Ulcers
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] Tobacco Use
- [ ] Tuberculosis
- [ ] Venereal Disease

**Please explain/clarify any conditions or allergies selected above:**

**Clarification of conditions or allergies listed above:**

Any conditions or allergies not listed above:

Have you been told you need to take pre-medication before dental appointments?

- ○ Yes
- ○ No

Pre-medication:

Primary Care Physician

Phone Number

Specialist

Preferred Pharmacy

Phone Number

(___) ___-____

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

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Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? *

○ Yes ○ No

If yes, please list all medications and dosages below:

☐ 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. *

When was your last dental appointment? *

Was your last dental appointment for? *

☐ Hygiene
☐ Consult
☐ Problem Focused Exam
☐ Other

Are there any concerns or questions you have about your teeth or gums? *

***THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY***

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

Patients First Name *

Patients Last Name *

MI

Preferred Name

Title

Mr/Ms/Mrs/etc

Gender

○ Male ○ Female

Family Status

○ Married ○ Single ○ Child
○ Other

Date of Birth

__/__/____

Home Phone

(___) ___-____

Mobile Phone

(___) ___-____

Work Phone

(___) ___-____

Work Ext

Prev. Visit

mm/dd/yyyy

Email

Best time to call