PATIENT INFORMATION AND MEDICAL HISTORY

Print Form

Today's Date:

Name: How do you wish to be addressed?

Address: City: State: Zip:

Ph: Cell: Soc. Sec. #: Date of Birth:

Patient's/Parents Employer: Work Phone:

Spouse's/Parent's Name:

Person financially responsible for this account:

Physician's Name: Phone: Date of last physical:

Whom may we thank for the referral?:

Email address:

DO YOU REQUIRE PREMEDICATION WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT? ☐ Yes ☐ No

ANTIBIOTIC PRESCRIBED:

ALLERGIES: (please list all - including medications)

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?: (please check Y or N)

☐ Y ☐ N Mitral Valve Prolapse	☐ Y ☐ N Ulcers	☐ Y ☐ N Liver Disease	☐ Y ☐ N Latex Allergy
☐ Y ☐ N Premedication	☐ Y ☐ N Cough	☐ Y ☐ N Asthma	☐ Y ☐ N Reaction to Jewelery
☐ Y ☐ N Pacemaker	☐ Y ☐ N Headaches	☐ Y ☐ N Tuberculosis	☐ Y ☐ N Reaction to Rubber
☐ Y ☐ N Heart Trouble	☐ Y ☐ N Fibromyalgia	☐ Y ☐ N Hepatitus	☐ Y ☐ N Kidney Problem
☐ Y ☐ N Heart Murmur	☐ Y ☐ N Serious Accident	☐ Y ☐ N Arthritis	WOMEN: Might you be pregnant?
☐ Y ☐ N Prosthetic Replacement	☐ Y ☐ N Diabetes	☐ Y ☐ N Acid Reflux	☐ Y ☐ N
☐ Y ☐ N H. Valve Replacement	☐ Y ☐ N Rheumatic Fever	☐ Y ☐ N Excessive Bleeding	Hormone Therapy?
☐ Y ☐ N Art. Joint Replacement	☐ Y ☐ N High Blood Pressure	☐ Y ☐ N S.T.D.'s	☐ Y ☐ N
☐ Y ☐ N Allergies	☐ Y ☐ N Low Blood Pressure	☐ Y ☐ N Swollen Ankles	
☐ Y ☐ N Medical Problem	☐ Y ☐ N Pain in Chest	☐ Y ☐ N Anemia	Are you currently under a Dr.'s care? If so, why?
☐ Y ☐ N Change in weight	☐ Y ☐ N Shortness of Breath	☐ Y ☐ N Hyperthyroidism	
☐ Y ☐ N Insomnia	☐ Y ☐ N Stroke	☐ Y ☐ N Hypothyroidism	
☐ Y ☐ N Alcohol Dependency	☐ Y ☐ N Heart Attack	☐ Y ☐ N Jaundice	
☐ Y ☐ N Tobacco Dependency	☐ Y ☐ N Major Surgery	☐ Y ☐ N Tumor/Cancer	
☐ Y ☐ N Depression	☐ Y ☐ N Trauma to Face/Jaw	☐ Y ☐ N Blood Transfusion	
☐ Y ☐ N Panic Attacks	☐ Y ☐ N HIV or AIDS	☐ Y ☐ N Radiation Therapy	
☐ Y ☐ N Psychiatric Treatment	☐ Y ☐ N Fainting/Dizzyness	☐ Y ☐ N Epilepsy	
☐ Y ☐ N Drug Dependency	☐ Y ☐ N Chronic Fatigue	☐ Y ☐ N Chemotherapy	