

Medical History

Patient First Name *

Patient Last Name *

Have you ever had any of the following medical conditions?

- | | | |
|---|---|--|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other |
| <input type="checkbox"/> Allergies - Seasonal | <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine |
| <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever | <input type="checkbox"/> Allergy - Latex |
| <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Heart Valve |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Mitral Valve Prolaps | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | |

Do you have any other health problems? *

- No Yes

Are you allergic to any of the following?

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Metals | <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Other allergies |

Other allergies not listed above

Are you taking any medications at this time? *

No Yes

Have you been admitted to a hospital in the last 2 years? *

No Yes

Are you under care of physician? *

No Yes

Do you use tobacco? *

No Yes

Do you use alcoholic beverages? *

No Yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? *

No Yes

Have you ever taken diet drug such Fen-Phen? *

No Yes

Women: Are you pregnant?

No Yes

Women: Do you take birth control medications?

No Yes

Women: Are you nursing?

No Yes

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Draw your signature into the box below. *

[Clear](#)

Relationship to the patient *

Name if not the patient *

Continue

Alexandria Smiles Dentistry