Emily Bland D.D.S

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Medical History

Patient Name: ______________________ ______________________ ___ ______________________

Last First MI Preferred Name

Height: ______________________

Weight: ______________________

Are you completing this form for another person? ◯ Yes ◯ No

If yes, name? ______________________

If yes, relationship? ______________________

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.

☐ *Pre-Med	☐ ADD/ADHD	☐ Allergy animals	☐ Allergy Codeine
☐ Allergy Latex	☐ Allergy Other Meds	☐ Allergy PCN,/Other	☐ Allergy to aspirin
☐ Alrg Barbiturates	☐ Alrg Codeine/Narcoti	☐ Alrg Food	☐ Alrg Local anestheti
☐ Alrg to Iodine	☐ Alrg to Sulfa drugs	☐ Anemia	☐ Arthritis
☐ Artif Heart Valve	☐ Artificial Joints	☐ Asthma	☐ Autism
☐ Autoimmune disease	☐ Barretts Esophagitis	☐ Bisphosphonates	☐ Bladder Problems
☐ Blood Thinners	☐ Blood transfusion	☐ Cancer	☐ Colitis
☐ Cong. Heart Disease	☐ Diabetes	☐ Emphysema	☐ Epilepsy/Seizures
☐ Epinephrine Sens.	☐ GI disease	☐ Glaucoma	☐ Growth Disorder
☐ Hay fever/Seasonal	☐ Heart Disease	☐ Heart Murmur	☐ Heart Transplant
☐ Hepatitis	☐ High Blood Pressure	☐ HIV/AIDS	☐ Hx of Stroke
☐ Hx of heart attack	☐ Infec. Endocarditis	☐ Kidney Disease	☐ Liver Disease
☐ Lupus	☐ MVP	☐ Pregnancy	☐ Psychiatric problems
☐ Radiation treatment	☐ Radiation/Chemo	☐ RepairCHDresi.defect	☐ RepCHDComp in 6 mos
☐ Rheumatic Fever	☐ Stroke	☐ Thyroid problem	☐ Tuberculosis
☐ UnrepairCyanotic CHD			

☐ No Medical Conditions ☐ Subject to frequent headaches ☐ Tobacco/Alcohol Use

☐ FEMALE: Pregnant or Planning Pregnancy ☐ FEMALE: Nursing

Do you have any of the following

☐ Active Tuberculosis ☐ Persistent cough greater 3 weeks duration

Have you had a cough that produces blood ◯ Yes ◯ No

Have you been exposed to anyone with tuberculosis ◯ Yes ◯ No

If you answered yes to any of the above questions PLEASE STOP AND RETURN THIS FORM to receptionist

If any conditions or alerts selected above need further clarification, please describe below:

____

____

____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

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:

___

___

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: ___________