Medical History

Last Name: First Name:

Phone number Birthdate:

Name of Medical Doctor: City/State:

Emergency Contact Phone Relationship

List all medications that you are now taking:

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Azithromycin (Z Pak)	☐	☐	Latex
☐	☐	Aspirin	☐	☐	Penicillin
☐	☐	Clindamycin	☐	☐	Sulfa
☐	☐	Codeine	☐	☐	Ibuprofen (Motrin)

Other Allergies:

Do you have any of the following medical conditions?

Y	N		Y	N	
☐	☐	Asthma/COPD/Pneumonia	☐	☐	Osteoporosis or Osteopenia
☐	☐	Diabetes Type 1 or 2	☐	☐	Heart Disease/Stroke
☐	☐	High Blood Pressure	☐	☐	Joint Replacement (hip/shoulder)
☐	☐	Kidney Disease	☐	☐	HIV Positive/AIDS
☐	☐	Blood Transfusion	☐	☐	Low Blood Pressure
☐	☐	Arthritis	☐	☐	High Cholesterol
☐	☐	Uclers (Stomach/Intestinal)	☐	☐	Epilepsy or Seizures
☐	☐	Hepatitis	☐	☐	Pacemaker
☐	☐	Thyroid Disease	☐	☐	Chemotherapy or Radiation
☐	☐	Psychiatric Treatment	☐	☐	Do you smoke cigarettes/marijuana?
☐	☐	Misc	☐	☐	Do you drink Alcohol?

Females:

☐ ☐ Did you have any complications during pregnancy (if you have never been pregnant mark NO)

☐ ☐ Are you pregnant?

☐ ☐ Are you taking oral contraceptives?

Dental History

☐ ☐ Have you had serious trouble associated with previous dental treatments?

☐ ☐ Do you bleed excessively after a tooth extraction?

☐ ☐ Have you had undesireable reactions to local or general anesthetic (Novocain or gas)?

☐ ☐ Do you clench or grind your teeth?

☐ ☐ Have you had excessive pain or swelling after oral surgery?

☐ ☐ Do you have bleeding gums?

☐ ☐ Do you have bad taste in your mouth?

☐ ☐ Does food impact between your teeth?

☐ ☐ Does your jaw click or pop when you chew?

☐ ☐ Have you received treatment for periodontal disease?