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" or "NO" response.

*Pre-Med *	◯ Yes ◯ No	ADD/ADHD *	◯ Yes ◯ No
Allergy animals *	◯ Yes ◯ No	Allergy Codeine *	◯ Yes ◯ No
Allergy Latex *	◯ Yes ◯ No	Allergy Other Meds *	◯ Yes ◯ No
Allergy PCN,/Other *	◯ Yes ◯ No	Allergy to aspirin *	◯ Yes ◯ No
Alrg Barbiturates *	◯ Yes ◯ No	Alrg Codeine/Narcoti *	◯ Yes ◯ No
Alrg Food *	◯ Yes ◯ No	Alrg Local anestheti *	◯ Yes ◯ No
Alrg to Iodine *	◯ Yes ◯ No	Alrg to Sulfa drugs *	◯ Yes ◯ No
Anemia *	◯ Yes ◯ No	Arthritis *	◯ Yes ◯ No
Artif Heart Valve *	◯ Yes ◯ No	Artificial Joints *	◯ Yes ◯ No
Asthma *	◯ Yes ◯ No	Autism *	◯ Yes ◯ No
Autoimmune disease *	◯ Yes ◯ No	Barretts Esophagitis *	◯ Yes ◯ No
Bisphosphonates *	◯ Yes ◯ No	Bladder Problems *	◯ Yes ◯ No
Blood Thinners *	◯ Yes ◯ No	Blood transfusion *	◯ Yes ◯ No
Cancer *	◯ Yes ◯ No	Colitis *	◯ Yes ◯ No
Cong. Heart Disease *	◯ Yes ◯ No	Diabetes *	◯ Yes ◯ No
Emphysema *	◯ Yes ◯ No	Epilepsy/Seizures *	◯ Yes ◯ No
Epinephrine Sens. *	◯ Yes ◯ No	GI disease *	◯ Yes ◯ No
Glaucoma *	◯ Yes ◯ No	Growth Disorder *	◯ Yes ◯ No
HIV/AIDS *	◯ Yes ◯ No	Hay fever/Seasonal *	◯ Yes ◯ No
Heart Disease *	◯ Yes ◯ No	Heart Murmur *	◯ Yes ◯ No
Heart Transplant *	◯ Yes ◯ No	Hepatitis *	◯ Yes ◯ No
High Blood Pressure *	◯ Yes ◯ No	Hx of Stroke *	◯ Yes ◯ No
Hx of heart attack *	◯ Yes ◯ No	Infec. Endocarditis *	◯ Yes ◯ No
Kidney Disease *	◯ Yes ◯ No	Liver Disease *	◯ Yes ◯ No
Lupus *	◯ Yes ◯ No	MVP *	◯ Yes ◯ No
Pregnancy *	◯ Yes ◯ No	Psychiatric problems *	◯ Yes ◯ No
Radiation treatment *	◯ Yes ◯ No	Radiation/Chemo *	◯ Yes ◯ No
RepCHDComp in 6 mos *	◯ Yes ◯ No	RepairCHDresi.defect *	◯ Yes ◯ No
Rheumatic Fever *	◯ Yes ◯ No	Stroke *	◯ Yes ◯ No
Thyroid problem *	◯ Yes ◯ No	Tuberculosis *	◯ Yes ◯ No
UnrepairCyanotic CHD *	◯ Yes ◯ No	**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 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.**

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

Response Date: _____