Medical History Form

Do you have any of the following Conditions?

Do you have any of the following Conditions?

*Pre-Med - Amox *

Yes No

*Pre-Med - Clind *

Yes No

*Pre-Med - Other *

Yes No

ADHD-Ritalin *

Yes No

Allergies *

Yes No

Allergy - Aspirin *

Yes No

Allergy - Codeine *

Yes No

Allergy - Erythro *

Yes No

Allergy - Hay Fever *

Yes No

Allergy - Latex *

Yes No

Allergy - Other *

Yes No

Allergy - Penicillin *

Yes No

Allergy - Sulfa *

Yes No

Allergy- Amoxicillin *

Yes No

Anemia *

Yes No

Arthritis *

Yes No

Artificial Joints *

Yes No

Asthma *

Yes No

Fainting *

Yes No

Glaucoma *

Yes No

Head Injuries *

Yes No

Headaches *

Yes No

Headaches *

Yes No

Heart Disease *

Yes No

Heart Murmur *

Yes No

Heart Problems Lipid *

Yes No

Hepatitis *

Yes No

High Blood Pressure *

Yes No

HIV *

Yes No

Jaundice *

Yes No

Kidney Disease *

Yes No

Liver Disease *

Yes No

Mental Disorders *

Yes No

Nervous Disorders *

Yes No

Other *

Yes No

Pacemaker *

Yes No

◯ Yes ◯ No

◯ Yes ◯ No

Autistic *

◯ Yes ◯ No

Bipolar *

◯ Yes ◯ No

Birth Defects *

◯ Yes ◯ No

Blood Disease *

◯ Yes ◯ No

Cancer *

◯ Yes ◯ No

Cerebral Palsy *

◯ Yes ◯ No

Cystic Fibrosis *

◯ Yes ◯ No

Diabetes *

◯ Yes ◯ No

Difficulty w/ Speech *

◯ Yes ◯ No

Dizziness *

◯ Yes ◯ No

Down Syndrome *

◯ Yes ◯ No

Emotional Disorder *

◯ Yes ◯ No

Epilepsy *

◯ Yes ◯ No

Excessive Bleeding *

◯ Yes ◯ No

Pregnancy *

◯ Yes ◯ No

Radiation Treatment *

◯ Yes ◯ No

Respiratory Problems *

◯ Yes ◯ No

Rheumatic Fever *

◯ Yes ◯ No

Rheumatism *

◯ Yes ◯ No

Sinus Problems *

◯ Yes ◯ No

Skin Rash *

◯ Yes ◯ No

Stomach Problems *

◯ Yes ◯ No

Stroke *

◯ Yes ◯ No

Thyroid Disease *

◯ Yes ◯ No

Tuberculosis *

◯ Yes ◯ No

Tumors *

◯ Yes ◯ No

Ulcers *

◯ Yes ◯ No

Venereal Disease *

◯ Yes ◯ No

Add unlisted conditions here (one item per entry)

Enter the item not listed here

Additional Questions

Additional Questions

Date of last exam

MM/dd/yyyy

Have you had any serious illness, operation, or hospitalization in the past 5 years? *

◯ Yes ◯ No

Are you on a special diet? *

◯ Yes ◯ No

Have you had any head or neck injuries? *

◯ Yes ◯ No

Do you experience any tooth sensitivity? *

◯ Yes ◯ No

Do you grind your teeth? *

◯ Yes ◯ No

Do you smoke or chew tobacco? *

◯ Yes ◯ No

Patient's First Name *

Patient's Last Name *