Snodgrass-King Dental

Medical Information Form

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following question.

Patient Name _____ **DOB** _____

Emergency contact name (other than yourself): _____ Phone: _____

Relationship to patient: _____

Medical Questionnaire

Family Physician _____ Phone # _____

Are you currently under care of a Physician? Yes ◯ No ◯ If yes, please explain: _____

Have you been hospitalized or had major surgery? Yes ◯ No ◯ If yes, please explain: _____

Are you currently taking any medication? Yes ◯ No ◯ If yes, please explain: _____

Have you ever taken the diet control drug Fen-Phen? Yes ◯ No ◯

Do you smoke or use smokeless tobacco? Yes ◯ No ◯ Frequency? _____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) Yes ◯ No ◯

Women Only

Are you pregnant? Yes ◯ No ◯ If Yes, what is your due date? _____

Are you currently nursing? Yes ◯ No ◯

Are you on hormone replacement therapy? Yes ◯ No ◯

Are you on birth control pills / fertility drugs? Yes ◯ No ◯

Do you have, or have you had, any of the following?

Allergic To

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Lodine
- ☐ Barbiturates / Sleeping Pills
- ☐ Codeine
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex Rubber
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Epinephrine
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Dyes
- ☐ Gluten
- ☐ Other

Check, if applicable

- ☐ Current Concerns or Issues
- ☐ ADHD
- ☐ AIDS/HIV Infection
- ☐ Alcohol/Drug Abuse
- ☐ Anaphylaxis
- ☐ Anemia / Leukemia
- ☐ Anorexia / Bulimia
- ☐ Arthritis
- ☐ Asthma / Hay Fever
- ☐ Aspergers
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Downs Syndrome
- ☐ Blood Clotting Problems
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer / Tumor or Growth
- ☐ Radiation Treatment
- ☐ Cardiac Pacemaker
- ☐ Chest Pain Upon Exertion
- ☐ Prosthetic Heart Valve
- ☐ Diabetes
- ☐ Emphysema
- ☐ Environmental Allergies
- ☐ Epilepsy
- ☐ Fainting Spells / Seizures
- ☐ Fever Blisters / Herpes
- ☐ Frequent Headaches
- ☐ Frequently Dry Mouth / Sjogren
- ☐ Gag Reflex
- ☐ Hearing Impaired
- ☐ Congenital Heart Disease
- ☐ Heart Attack / Stroke
- ☐ Heart Disease / Angina
- ☐ Heart Murmur
- ☐ previous endocarditis
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Hives / Skin Rash
- ☐ Jaundice
- ☐ Hypoglycemia
- ☐ Joint Replacement
- ☐ Kidney / Bladder Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ ODD
- ☐ Psychiatric Care
- ☐ Running Fever
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Sensory Disorder
- ☐ Sexually Transmitted Disease
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Stomach Ulcers
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vision Impaired
- ☐ Sickle Cell Anemia
- ☐ Other Syndrome or Disorder

Other:

- ☐ Premedicate

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature **Date**