MEDICAL HISTORY

SOUTHWEST DENTISTRY

Please list **ALL** medications by **NAME** including **OTC** medications.

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Are you allergic to any of the following:

Y ☐ N ☐ **Anesthetic** Y ☐ N ☐ **Aspirin** Y ☐ N ☐ **Codeine** Y ☐ N ☐ **Iodine**
Y ☐ N ☐ **Latex** Y ☐ N ☐ **Penicillin** Y ☐ N ☐ **Sulfa**
Y ☐ N ☐ **Other** _____

Are you required to premedicate prior to dental appointments? Y ☐ N ☐
If so, what medication do you take? _____ Pharmacy Phone# _____

Primary Care Physician _____ Primary Care Physician Phone# _____

Do you have **ANY** of the following medical conditions, **AND/OR** being treated for?
Please mark **YES** or **NO, DO NOT LEAVE ANY BLANK.**

Y ☐ N ☐ **Abnormal Bleeding**
Y ☐ N ☐ **Acid Reflux**
Y ☐ N ☐ **AIDS**
Y ☐ N ☐ **Alcohol Abuse**
Y ☐ N ☐ **Allergies/Hay Fever**
Y ☐ N ☐ **Anemia**
Y ☐ N ☐ **Angina Pectoris (chest pain)**
Y ☐ N ☐ **Arthritis**
Y ☐ N ☐ **Asthma**
Y ☐ N ☐ **Bisphosphonates**
Y ☐ N ☐ **Blood Disorders**
Y ☐ N ☐ **Blood Transfusion**
Y ☐ N ☐ **Cancer**
Y ☐ N ☐ **Active** Y ☐ N ☐ **Remission**
Y ☐ N ☐ **Chemo** Y ☐ N ☐ **Radiation**
Type _____ **When** _____
Y ☐ N ☐ **Cardiovascular Disease**
Y ☐ N ☐ **Congenital Heart Defects**
Y ☐ N ☐ **Depression**
Y ☐ N ☐ **Diabetes 1**
Y ☐ N ☐ **Diabetes 2**
Y ☐ N ☐ **Difficulty Breathing**
Y ☐ N ☐ **Emphysema**
Y ☐ N ☐ **Epilepsy**
Y ☐ N ☐ **Fainting Spells**
Y ☐ N ☐ **Frequent Headaches**
Y ☐ N ☐ **Fever Blisters**
Y ☐ N ☐ **Glaucoma**
Y ☐ N ☐ **HIV**
Y ☐ N ☐ **Heart Attack** **When** _____
Y ☐ N ☐ **Heart Disease**
Y ☐ N ☐ **Heart Surgery** **When** _____
Y ☐ N ☐ **Hemophilia**
Y ☐ N ☐ **Hepatitis A**
Y ☐ N ☐ **Hepatitis B**
Y ☐ N ☐ **Hepatitis C**
Y ☐ N ☐ **Herpes**
Y ☐ N ☐ **High Blood Pressure**
Y ☐ N ☐ **High Cholesterol**
Y ☐ N ☐ **Hospilized in the past 5 yrs**
Why _____ **When** _____
Y ☐ N ☐ **Jaundice**
Y ☐ N ☐ **Joint Replacement**
Where _____ **When** _____
Y ☐ N ☐ **Kidney Problems**
Y ☐ N ☐ **Kidney Stones**
Y ☐ N ☐ **Liver Disease**
Y ☐ N ☐ **Low Blood Pressure**
Y ☐ N ☐ **Mitral Valve Prolapse**
Y ☐ N ☐ **Pacemaker** **When** _____
Y ☐ N ☐ **Psychiatric Problems**
Y ☐ N ☐ **PTSD**
Y ☐ N ☐ **Rheumatic Fever**
Y ☐ N ☐ **Seizures**
Y ☐ N ☐ **Shingles**
Y ☐ N ☐ **Sickle Cell**
Y ☐ N ☐ **Sinus Problems**
Y ☐ N ☐ **Sores lasting more than 1 week**
Y ☐ N ☐ **Stroke** **When** _____
Y ☐ N ☐ **Thyroid Problems**
Y ☐ N ☐ **Turbercolosis, Lung Ailments**
Y ☐ N ☐ **Venereal Disease**
Y ☐ N ☐ **Other** _____

Y ☐ N ☐ **Pregnant**
Y ☐ N ☐ **Nursing**

Patient's Name _____ Signature _____
Date _____

3391 FARM BANK WAY • GROVE CITY, OHIO 43123 • 614-594-2002