# LINDSBORG FAMILY DENTAL CARE

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## MEDICAL HISTORY

**Patient Name:** _____ * _____ * _____

Last First MI

_____

Preferred Name

**Have you ever had any of the following? Please check all that apply:**

- ☐ AIDS/HIV Positive
- ☐ Allergy, Anesthetic
- ☐ Allergy, Codeine
- ☐ Allergy, Drug
- ☐ Allergy, Latex
- ☐ Allergy, Penicillin
- ☐ Allergy, Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Vlv
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism/Asperger's
- ☐ Autoimmune Disease
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Clindamycin
- ☐ Cortisone Treatments
- ☐ Cough Up Blood
- ☐ Cough, Persistent
- ☐ Current Medications
- ☐ Dental Implants
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Doxycycline
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack/Angina
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A, B or C
- ☐ Herpes/Cold Sores
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Jaw Pain/TMJ
- ☐ Keflex
- ☐ Kidney Disease
- ☐ Lipitor
- ☐ Liver Disease
- ☐ Mitral Vlv Prolapse
- ☐ Neurological Condit.
- ☐ Osteoporosis
- ☐ Other
- ☐ Pacemaker/Stents
- ☐ Penicillin
- ☐ Pre-Medicate
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Rash/Hives
- ☐ STD/HPV
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgical Implant
- ☐ Tuberculosis
- ☐ Ulcers/Colitis

- ☐ Tobacco Use, past or present
- ☐ Recent Hospitalization, explain below
- ☐ Alcohol Use, > than 3 drinks/week
- ☐ Being treated for other condition, explain below
- ☐ Currently Pregnant
- ☐ Surgery, past or impending, explain below
- ☐ Currently Nursing

**If any conditions selected need further clarification, please explain below**

_____

_____

_____

**List all medications (prescription, non-prescription and vitamins). Include medications used regularly and on an as needed basis. ***

**Please list any allergies and/or allergies to medications. ***

**Do you take antibiotic premedication for your dental visits? If yes, please explain.**

**Family Physician's Name, address and phone number ***

**When was your last physical exam?**

**Please list any other doctor or specialist you see, their phone number and the condition they are treating.**

**Please provide any other medical information that you feel we should be aware of:**

☐ ***I verify that all the above information is correct to the best of my knowledge. If anything changes, I will inform the staff of Lindsborg Family Dental Care prior to my next appointment.**

**Name and relationship of individual completing this form, if other than patient:**

**Response Date:**