# Chesaning Family Dental, PC

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## Medical History

Patient Name: _____ _____ ____ _____
Last First Mi Preferred Name

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name and Phone:

_____

_____

Date of last visit: _____

Your current physical health is:

☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:

_____

_____

Do you have, or have you had, any of the following? If yes, please indicate by checking next to condition.

- ☐ Allergy – Local anesthetics ("Novocaine")
- ☐ Allergy – Acetaminophen or Ibuprofen
- ☐ Chest Pain
- ☐ Skin rashes
- ☐ Chemo or Radiation
- ☐ Chew tobacco
- ☐ History of head injury
- ☐ Bruxism or Grinding
- ☐ Sleep Apnea
- ☐ Allergy – Barbiturates, sedatives, or sleeping pills
- ☐ Allergy – Demoral or other narcotics
- ☐ Easy Bruising
- ☐ Back or Neck Pain
- ☐ Smoke
- ☐ Herpes or other STD
- ☐ Frequent or severe headaches
- ☐ Jaw pain TMJ
- ☐ Snoring

Do you have, or have you had, any of the following? If yes, please indicate by checking next to condition.

| | | | |
|---|---|---|---|
| ☐ Allergy – All Other | ☐ Allergy – Ampicillin | ☐ Allergy – Anesthesia | ☐ Allergy – Aspirin |
| ☐ Allergy – Augmentin | ☐ Allergy – Bactrim | ☐ Allergy – Cardizem | ☐ Allergy – Cefatin |
| ☐ Allergy – Cephalexin | ☐ Allergy – Cleosin | ☐ Allergy – Codeine | ☐ Allergy – Iodine |
| ☐ Allergy – Latex | ☐ Allergy – Lodine | ☐ Allergy – Metals | ☐ Allergy – Penicillin |
| ☐ Allergy -Quinolones | ☐ Allergy – Sulfa | ☐ Allergy – Sulfur | ☐ Allergy – Suprax |
| ☐ Allergy – Epinephrine | ☐ Allergy – Cephalosporin | ☐ Allergy – Erythromycin | ☐ Anemia |
| ☐ Arthritis | ☐ Artificial Joints | ☐ Asthma | ☐ Autism Spectrum |
| ☐ Blood Disease | ☐ Blood Pressure | ☐ Blood Thinner | ☐ Cancer |
| ☐ Diabetes | ☐ Epilepsy/Seizures | ☐ Excessive Bleeding | ☐ Fainting |
| ☐ Glaucoma | ☐ Hay Fever | ☐ Heart Condition | ☐ Heart Murmur |
| ☐ Hepatitis | ☐ HIV | ☐ Jaundice | ☐ Kidney Disease |
| ☐ Liver Disease | ☐ Mental Disorders | ☐ Nervous Disorders | ☐ On a Bisphosphonate |
| ☐ Pacemaker | ☐ Pregnancy | ☐ Pre-med | ☐ Respiratory Problems |
| ☐ Rheumatic Fever | ☐ Rheumatism | ☐ Rubber and Latex | ☐ Sinus Problems |
| ☐ Stomach Problems | ☐ Stroke | ☐ Thyroid Problems | ☐ Tuberculosis |
| ☐ Tumors | ☐ Venereal Disease | | |

If you have indicated that you have any of the above conditions, please explain.

_____

_____

Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe.

_____

_____

Are you taking any medications or drugs (including nutritional supplements? ☐ Yes ☐ No

Please list all medication you are taking.

_____

_____

Please list all medication you are taking.

_____

_____

Please list any major surgeries you have had.

_____

_____

If female, please indicate by checking.

☐ Taking Contraceptives ☐ Taking other hormones ☐ Nursing ☐ Reached Menopause

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

**Signature** _____**Date**_____**Response Date:**_____