Allison Jung Family Dentistry
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Medical History

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Premed
- ☐ Allergy - Codeine
- ☐ Allergy -Penicillin
- ☐ Aspirin daily
- ☐ Cancer
- ☐ Dizziness/Fainting
- ☐ Glaucoma
- ☐ Hepatitis A,B,C
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Radiation /Chemo
- ☐ Stroke
- ☐ Ulcers
- ☐ ADD/ADHD
- ☐ Allergy - Other Meds
- ☐ Anemia
- ☐ Asthma
- ☐ Coumadin
- ☐ Do Not Resuscitate
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Mental Disorders
- ☐ No Pre-med Needed
- ☐ Respiratory Problems
- ☐ TMJ
- ☐ Allergic to Metals
- ☐ Allergy - Sulfa
- ☐ Arthritis
- ☐ Autism
- ☐ Defibrillator
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ Mitral Valve Prolaps
- ☐ Other
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Allergy - Amox
- ☐ Allergy- Latex
- ☐ Artificial Joints
- ☐ Bisphosphonates
- ☐ Diabetes I or II
- ☐ Excessive Bleeding
- ☐ Heart Murmur
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ STD's
- ☐ Tumors

- ☐ No Medical Conditions
- ☐ Alcohol Use
- ☐ FEMALE: Nursing
- ☐ Subject to frequent headaches
- ☐ Marijuana Use
- ☐ Tobacco Use
- ☐ FEMALE: Pregnant or Planning Pregnancy

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

_____

Previous infective endocarditis? ◯ Yes ◯ No

Do you take antibiotic premedication for your dental visits? If yes, please explain below. * ◯ Yes ◯ No

Pre-Med:

_____

_____

Are you taking any medications (prescription and non-prescription) including regular doses of aspirin or birth control pills? If yes, please list below. *

◯ Yes ◯ No

Medications:

_____

_____

_____

Have you taken or are you taking any Bisphosphonate drug used to treat osteoporosis or Paget's disease? Examples; Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa etc. If yes, please list the drug and date taken. *

◯ Yes ◯ No

Bisphosphonates

Do you have any allergies (including allergies to medications)? If yes, please explain below * ◯ Yes ◯ No

Allergies:

Name of your Physician and phone number:

Name and phone number of preferred Pharmacy:

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

Please refrain from alcoholic beverages and non medically prescibed drugs at least 12 hours prior to dental treatment

Are you or have you used tobacco products, including smokeless tobacco or snuff? ◯ Yes ◯ No

If yes:
Product(s) (i.e. cigarettes), Amount (i.e. 1 ppd) , Duration (i.e.5 years)

Are you or have you used drugs including controlled substances and marijuana? ◯ Yes ◯ No

Do you drink alcoholic beverages? ◯ Yes ◯ No

☐ * By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Response Date: ___/___/_____