Gardens Dental Spa

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Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

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.

- ☐ Allergy-Aspirin
- ☐ Allergy-Barbiturate
- ☐ Alzheimers Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Val
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Codeine Allergy
- ☐ Cortisone Treatments
- ☐ Cough, persistent
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ HIV/ AIDS
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing Impaired
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Iodine allergy
- ☐ Jaundice
- ☐ Jaw pain
- ☐ Keflex allergy
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Local Anesthetic
- ☐ Mental Disorders
- ☐ Mitral Valve Prolaps
- ☐ Morphine allergy
- ☐ Nervous Disorders
- ☐ Neurological problem
- ☐ Other
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Percodan allergy
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shortness of breathe
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Sores Blisters Growt
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Sulfa allergy
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

Allergies not listed:

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

Pre-Med:

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

☐ ***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.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: _____

FOR OFFICE USE ONLY

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

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Response Date: _____