

WILLIAMSBURG SMILES

400 Elm Street, Williamsburg, IA,
USA

(319) 668-1221



Medical History

Medical History

Patient First Name _____

Patient Last Name _____

Patient Birth Date _____

Are you under the care of a physician? **yes / no**

Please add your physician name and contact information here _____

Have you ever been hospitalized or had a major operation? **yes / no**

Please add any details here _____

Have you ever had a serious head or neck injury? **yes / no**

Please add any details here _____

Do you take, or have you taken, Phен-Fen or Redux? **yes / no**

Please add any details here _____

Do you or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? **yes / no**

Please add any details here _____

Are you on a special diet? **yes / no**

Please add any details here _____

Do you use tobacco? **yes / no**

Please add any details here _____

Do you use controlled substances? **yes / no**

Please add any details here _____

Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your dental appointment? **yes / no**

Please add any details here _____

Do you take any blood thinners? **yes / no**

Please add any details here

Have you ever had endocarditis? **yes / no**

Please add any details here

Were you born with a congenital heart defect? **yes / no**

Please add any details here

Do you have an artificial heart valve? **yes / no**

Please add any details here

Are you allergic to Penicillin? **yes / no**

Please add any details here

Do you have any artificial joints? **yes / no**

Please add any details here

Are you pregnant or trying to get pregnant? **yes / no**

Are you nursing? **yes / no**

Are you taking oral contraceptives? **yes / no**

Do you have any allergies?

Allergies

- | | |
|--|--|
| <input type="checkbox"/> Animals | <input type="checkbox"/> Barbiturates or sedatives |
| <input type="checkbox"/> Codeine or other narcotics | <input type="checkbox"/> Food |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Seasonal |
| <input type="checkbox"/> Sulfa drugs | |
| <input type="checkbox"/> Other | |

Please add any details here

Do you have any medical conditions? We need this information to keep you healthy and safe

Lung or Breathing Conditions

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis |

Neurological Conditions

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Brain aneurysm |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Migraines/severe headaches |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke |

Heart or Circulatory Conditions

- | | |
|---|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Arteriosclerosis |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Cardiovascular disease |
| <input type="checkbox"/> Congenital Heart Disease (CHD) | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heart transplant |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Infective endocarditis |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Rheumatic heart disease | |

Digestive or Dietary Conditions

- | | |
|---|--|
| <input type="checkbox"/> Acid reflux/persistent heartburn | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Gastrointestinal disease |
| <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Severe or rapid weight loss |
| <input type="checkbox"/> Special diet | |

Autoimmune Conditions

- | | |
|---|---|
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Celiac disease |
| <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Immune deficiency |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Rheumatoid arthritis | |

General Diseases

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding disorder/Hemophilia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Jaundice or Liver disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Renal/Kidney problems | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Total joint replacement |

Other

Please add any details here

Do you take any medications?

Pain Medications

- | | |
|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Demerol (Meperidine) | <input type="checkbox"/> Hydrocodone (Vicodin/Lortan/Norco) |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Percocet (Oxycodone) |
| <input type="checkbox"/> Ultram (Tramadol) | |

Antibiotics

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Ciprofloxacin |
| <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Doxycycline |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Zithromax (Azithromycin) |

Antidepressant and Anxiety

- | | |
|---|---|
| <input type="checkbox"/> Adderall | <input type="checkbox"/> Ambien (Zolpidem) |
| <input type="checkbox"/> Celexa (Citalopram) | <input type="checkbox"/> Cymbalta (Duloxetine) |
| <input type="checkbox"/> Effexor (Venlafaxine) | <input type="checkbox"/> Lexapro (Escitalopram) |
| <input type="checkbox"/> Neurontin (Gabapentin) | |

Allergy or Asthma

- | | |
|--|---|
| <input type="checkbox"/> Claritin (Loratadine) | <input type="checkbox"/> Flonase (Fluticasone) |
| <input type="checkbox"/> Singulair (Montelukast) | <input type="checkbox"/> Ventolin (Albuterol Inhaler) |
| <input type="checkbox"/> Zyrtec (Cetirizine) | |

Diabetes, Cholesterol, or Blood Pressure

- | | |
|--|--|
| <input type="checkbox"/> Avapro (Irbesartan) | <input type="checkbox"/> Coreg (Carvedilol) |
| <input type="checkbox"/> Coumadin (Warfarin) | <input type="checkbox"/> Crestor (Rosuvastatin) |
| <input type="checkbox"/> Klor-Con (Potassium Chloride) | <input type="checkbox"/> Lasix (Furosemide) |
| <input type="checkbox"/> Lipitor (Atorvastatin Calcium) | <input type="checkbox"/> Lopressor (Metoprolol) |
| <input type="checkbox"/> Losartan (Cozaar) | <input type="checkbox"/> Metformin (Glucophage) |
| <input type="checkbox"/> Microzide (Hydrochlorothiazide) | <input type="checkbox"/> Norvasc (Amlodipine) |
| <input type="checkbox"/> Plavix (Clopidogrel) | <input type="checkbox"/> Pravachol (Pravastatin) |
| <input type="checkbox"/> Prinivil (Lisinopril) | <input type="checkbox"/> Tenormin (Atenolol) |
| <input type="checkbox"/> Toprol XL (Metoprolol) | <input type="checkbox"/> Tricor (Fenofibrate) |
| <input type="checkbox"/> Zestoretic (Lisinopril) | <input type="checkbox"/> Zocor (Simvastatin) |

General Medications

- | | |
|--|---|
| <input type="checkbox"/> Aclasta/Reclast (Zoledronic Acid) | <input type="checkbox"/> Boniva (Ibandronate) |
| <input type="checkbox"/> Cialis (Tadalafil) | <input type="checkbox"/> Cyclobenzaprine (Flexeril) |
| <input type="checkbox"/> Didronel (Etidronate) | <input type="checkbox"/> Fosamax (Alendronate) |
| <input type="checkbox"/> Medrol (Methylprednisolone) | <input type="checkbox"/> Meloxicam (Mobic) |
| <input type="checkbox"/> Pantoprazole (Protonix) | <input type="checkbox"/> Prednisone |
| <input type="checkbox"/> Prilosec (Omeprazole) | <input type="checkbox"/> Synthroid (Levothyroxine) |
- Other

Please add any details here

Have you ever had any serious illness not listed above? **yes / no**

Please add any details here

I certify that I have read and I understand the questions asked. I certify I have answered these questions in completion and do not hold the practice, doctor(s), or team responsible for any errors or omission that I have made in completing these forms.

I agree the above information is correct to the best of knowledge

Signature

Signature By Patient

Date signed:

Patient's Signature

By drawing in the box above I understand and agree that this is a legal representation of my signature

Signature By Guardian

Name*

Relationship*

Date signed:

Legal Guardian's Signature



By drawing in the box above I understand and agree that this is a legal representation of my signature