HARRELL Dental Implant Center

MEDICAL INFORMATION

DATE_____

MEDICAL HISTORY:

Primary Care Physician's Name _____

Practice Name _____PhoneNumber_____

Are you currently under a physician's care ---------- ☐ Yes ☐ No
Have you been hospitalized in the last 5 years?---------- ☐ Yes ☐ No
Any serious illnesses or surgeries ---------- ☐ Yes ☐ No
Do you use tobacco in any form? ☐ Yes ☐ No If yes, explain: _____

Do you have to pre-medicate before your dental appt due to heart condition or artificial joints?----- ☐ Yes ☐ No
if yes, what medication do you take and dosage _____

Do you know of any reason why routine dental procedures might post a risk to you, our staff, or other patient's? ---
☐ Yes ☐ No If yes, explain:_____

If there is any important medical condition(s) we need to be aware of please describe:

Are you taking any prescription or daily OTC medications/drugs?— ☐ Yes ☐ No
If yes, List in Medication Section

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE

☐ ACID REFLUX	☐ BULIMIA	☐ HEARING PROBLEMS	☐ PSYCHIATRIC TREATMENT
☐ ADHD	☐ CANCER/MALIGNANCY	☐ HEART ATTACK	☐ RADIATION/CHEMO
☐ AIDS/HIV	☐ CEREBRAL PALSY	☐ HEART DISEASE	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ CHEMICAL DEPENDENCY	☐ HEART MURMUR	☐ RHEUMATIC FEVER
☐ ANOREXIA	☐ CHICKEN POX	☐ HEPATITIS	☐ SINUS PROBLEMS
☐ ANXIETY	☐ CONVULSIONS	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ ARTIFICIAL HEART VALVE	☐ DEPRESSION	☐ KIDNEY DISEASE	☐ THYROID CONDITION
☐ ARTIFICIAL JOINTS	☐ DIABETES	☐ LIVER PROBLEMS	☐ TUBERCULOSIS
☐ ARTHRITIS	☐ DIZZINESS/FAINTING	☐ MITRAL VALVE PROLAPSE	☐ ULCERS
☐ ASTHMA	☐ EPILEPSY/SEIZURES	☐ MONONUCLEOSIS	☐ VENEREAL DISEASE
☐ AUTISM/ASPERGER'S	☐ FREQUENT EAR INFECTIONS	☐ PACEMAKER	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ ANESTHETIC – LOCAL	☐ DAIRY	☐ METAL SENSITIVITY	☐ SULFA DRUGS
☐ BARBITURATES	☐ LATEX	☐ NITROUS OXIDE SEDATION	☐ PENICILLIN/OTHER ANTIBIOTICS
☐ OTHER – PLEASE LIST:			