Willett Dental Associates

WillettDentalAssociates.com
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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 Amoxicillin
- ☐ Allergy Codeine
- ☐ Allergy Iodine
- ☐ Allergy Latex
- ☐ Allergy Nickel
- ☐ Allergy Penicillin
- ☐ Allergy Sulfa
- ☐ AllergyAcetominaphen
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ COPD
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ HIV/AIDS
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Iodine
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Low Blood Sugar
- ☐ Meloxicam
- ☐ Memory Loss
- ☐ Mental Disorders
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinsons
- ☐ Pre-med/antibiotics
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ nitroglycerin
- ☐ treenuts
- ☐ trigeminal neuralgia

Are you currently pregnant? * ◯ Yes ◯ No

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

Allergies not listed:

Do you experience dental anxiety or any other type of anxiety we should be aware of? ◯ Yes ◯ No

If yes, please describe:

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

Pre-Med:

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:

Please list all recreational habits:

☐ Smoking ☐ Vaping ☐ Chew tobacco ☐ Marijuana use ☐ Other drugs

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

Emergency Contact Name, Phone and Relationship to patient

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

☐ ***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: _____