Hudson View Dental

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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.

- ☐ *PRE- MED
- ☐ Artificial Joints
- ☐ Codeine
- ☐ Epilepsy
- ☐ Growths
- ☐ Heart Murmur
- ☐ HIV
- ☐ Latex Allergy
- ☐ Narcotics
- ☐ Pain Meds
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Ulcers
- ☐ Amoxicillian
- ☐ Asthma
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Hay Fever
- ☐ Hepatitis
- ☐ Hormone Imbalance
- ☐ Latex Allergy
- ☐ Osteoporosis
- ☐ Penicillin Allergy
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Anemia
- ☐ Blood Disease
- ☐ Dizziness
- ☐ Fainting
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Hypothyroidism
- ☐ Liver Disease
- ☐ Other
- ☐ Pre-Med
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Epi sensitivity
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Cholestrol
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tumors

- ☐ Ever been hospitalized (illness or injury)
- ☐ Subject to frequent headaches
- ☐ Alcohol Use
- ☐ Presently being treated for any other illnesses
- ☐ Tobacco use
- ☐ FEMALE: check box if you are currently pregnant?

Medical History

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

_____

_____

What medications are you ALLERGIC to? _____

Do you take antibiotic premedication for your dental visits? If yes, please explain. * _____

Name of your physician and phone number:

_____

_____

Name of preferred pharmacy and phone number:

_____

_____

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

List all medications (prescription and non-prescription) including regular doses of aspirin:

☐ * **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.**

Verify and Update if any information has changed:

Personal Information:

Chart#: _____
FOR OFFICE USE ONLY

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

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

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

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

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

☐ **By checking this box and signing below, I acknowledge that I have read, completed the above information and agree to the contents.**

Signature _____ **Date** _____

Response Date: _____