India Hook Dental Care

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

Please indicate which of the following you have had or have at present.

- ☐ *Pre-Med
- ☐ Allergy-Aspirin
- ☐ Allergy-Nickel
- ☐ Allergy-Tylenol
- ☐ Artificial Joint
- ☐ Blood Thinners
- ☐ Chest Pains
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Osteoporosis
- ☐ Renal Dialysis
- ☐ Stroke
- ☐ Use CPAP
- ☐ Acid Reflux
- ☐ Allergy-Codeine
- ☐ Allergy-Other
- ☐ Alzheimer's/Dementia
- ☐ Artificial Valve
- ☐ Breathing Problem
- ☐ Complex Medical Hx
- ☐ Drug Addiction
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ Hepatitis A/B/C
- ☐ Hypoglycemia
- ☐ Liver Disease
- ☐ Other
- ☐ Rheumatic Fever
- ☐ SVT: No EPI
- ☐ AIDS/HIV Positive
- ☐ Allergy-Foods
- ☐ Allergy-Penicillin
- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Cancer
- ☐ Cong. Heart Defect
- ☐ Emphysema/COPD
- ☐ Fainting/Dizzy Spell
- ☐ Heart Murmur
- ☐ Herpes/Cold Sores
- ☐ Intestinal Disease
- ☐ Low Blood Pressure
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Disease
- ☐ Allergy-Anesthetics
- ☐ Allergy-Latex
- ☐ Allergy-Sulfa Drugs
- ☐ Arthritis/Gout
- ☐ Blood Disease
- ☐ Chemotherapy
- ☐ Cong. Heart Failure
- ☐ Endocarditis
- ☐ Glaucoma
- ☐ Heart Pacemaker
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ MitralValve Prolapse
- ☐ Radiation Treatment
- ☐ Sickle Cell Disease
- ☐ Tuberculosis

Please check all that apply:

- ☐ Pregnant/Planning Pregnancy/Nursing
- ☐ Headaches/Migraines
- ☐ No Medical Conditions
- ☐ Taking No Medications
- ☐ No Health Changes
- ☐ Smoke, Chew, or use Smokeless Tobacco

Please list any other medical conditions.

Please list any allergies.

Do you take antibiotic premedication for your dental visits? * ◯ Yes ◯ No

Describe any current medical treatment, recent hospitalizations or recent or impending surgery(s)

Name of physician and date of last physical exam

Name and phone number of preferred pharmacy *

List all medications (prescription and non-prescription), including regular dosages 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. I further consent to the performing of xrays and oral examinations.**

Response Date: _____