2023 Arnould Dental Medical History (Ages 18+)

Patient Name: Birth Date: Date Created:

Welcome to our office

Your mouth is a part of your entire body. Health problems/medications could have an important interrelationship with the dentistry you will receive.

Question	Answer	If yes
Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation or a serious head or neck injury?	○ Yes ○ No	If yes
PLEASE LIST ALL MEDICATIONS/Supplements/Herbs/pills	○ Yes ○ No	If yes
Do you take anything that thins the blood (aspirin,Plavix Coumadin/Warfarin,Eliquis,Plavix,Xarelto,Brilinta)?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other antiresorptive agent medications?	○ Yes ○ No	If yes
Have you ever taken Phen-Fen or Redux?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you use any form of tobacco or nicotine?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes
Do you use any kind of cannabis, cannabidiol, CBD, or marijuana products?	○ Yes ○ No	If yes
Do you drink alcohol and what frequency?	○ Yes ○ No	If yes
Have you ever been told you needed PREMEDICATION WITH AN ANTIBIOTIC prior to dental treatment?	○ Yes ○ No	If yes

For Women Only:

Pregnant/trying to get pregnant?	○ Yes ○ No	Nursing	○ Yes ○ No	Taking Birth Control	○ Yes ○ No

Allergies

Are you allergic to any of the following?

☐ Aspirin	☐ Codeine	☐ Penicillin/Amoxicillin	☐ Clindamycin
☐ Local Anesthetics	☐ Sensitive to Epinephrine	☐ Latex	☐ Nitrile
☐ Metal/Acrylic/Resin	☐ Sulfa Drugs	☐ Flavorings/Additives/Dyes	☐ Seasonal

Anything Else you are allergic to? ☐ If yes

Do you have, or have had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV positive	○ Yes ○ No	Diabetes/PreDiabetes	○ Yes ○ No	Pacemaker/Defibrillator	○ Yes ○ No	Rheumatic/Scarlet Fever	○ Yes ○ No
Alzheimer's Disease/Dementia	○ Yes ○ No	Drug/Alcohol Addiction	○ Yes ○ No	High blood pressure	○ Yes ○ No	Shingles	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Emphysema/Lung Disease	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Anemia	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No	Kidney Disease	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Angina/Chest Pains	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Fainting/Dizziness	○ Yes ○ No	Liver Disease/Jaundice	○ Yes ○ No	Stroke	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Low blood sugar	○ Yes ○ No	Swelling of limbs	○ Yes ○ No
Asthma	○ Yes ○ No	Glaucoma	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Auto Immune Disease	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cancer/Cancer Treatments	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No	Ulcers	○ Yes ○ No

Do you have or have had any serious condition or disease that is not listed above? ☐ If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

Signature of Patient or Guardian:

X

Date:__________