Medical Health History

Patient Name: _____ Birthdate: _____/_____/_____

Address: _____ Zip: _____ Home Phone:_____

CellPhone: _____ Email _____Employer_____

Employer Phone: _____ Emergency Contact _____ Phone _____

Primary Care Physician: _____ Phone: _____

Have you ever had any of the following conditions: (Check all that apply)

- ☐ Pacemaker
- ☐ Stent/Shunt
- ☐ Liver Disease
- ☐ None of the Above
- ☐ Artificial or Replacement Valve
- ☐ Previous History of Endocarditis
- ☐ High Blood Pressure
- ☐ Congenital Heart Defect with/without repair
- ☐ Artificial or Replacement Joints or Pins
- ☐ Hepatitis (Please specify type) _____

Are you allergic to or have you ever had an adverse reaction to any of the following: (Check all that apply)

- ☐ Penicillin
- ☐ Clindamycin
- ☐ Codeine
- ☐ None of the Above
- ☐ Amoxicillin
- ☐ Cipro
- ☐ Aspirin
- ☐ Tetracycline
- ☐ Benzocaine
- ☐ Latex
- ☐ Azithromycin (Z-Pak)
- ☐ Adhesive Tape
- ☐ NSAIDS (Advil. Celebrex)

Do you currently have or ever had any of the following: (Check all that Apply)

- ☐ Tuberculosis
- ☐ Type I Diabetes
- ☐ Asthma
- ☐ Heart Disease
- ☐ Bleeding Disorder
- ☐ Papilloma Virus
- ☐ Type II Diabetes
- ☐ Lung Condition
- ☐ Stroke
- ☐ None of the Above
- ☐ Herpes
- ☐ Anemia
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Autoimmune Disease (RA, Lupus, Sjogren's)
- ☐ Chemotherapy or Radiation Treatments
- ☐ Breathing or Respiratory Problems
- ☐ HIV

Choose Y/N Do you routinely take antibiotic pre-medication prior to dental visits

Choose Y/N Are you currently taking any blood thinners (such as Coumadin)?

Choose Y/N Have you ever noticed that you clench or grind your teeth?

Choose Y/N Do you snore or have sleep apnea?

Choose Y/N Are you pregnant?

Choose Y/N Are you taking birth control pills?

Choose Y/N Do you have any food allergies? If yes, please list: _____

Choose Y/N Do you consume alcohol? If yes, how many drinks per week? _____

Choose Y/N Do you use tobacco? If yes, what form: _____ How much_____

Choose Y/N Have you ever taken bisphosphonate drugs (such as Fosamax)? If so, was it taken: Orally or I.V. What was the dosage: _____ When did you start: _____ If you stopped, when:_____

Choose Y/N Have you ever had major surgery (organ transplant, open heart surgery, etc.)?
If yes, explain: _____

Do you have any other conditions that our office should be aware of?

_____

Please list ***ALL*** medications (including dosage) that you are taking and the reason for taking them:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Patient Signature: *_____ **Date:** *_____

Doctor Signature: _____ **Date:** _____

*If completing for digitally and emailing to us, you will be asked to sign and date when you arrive at your appointment. Please leave the fields for signature and date BLANK.

Revised 10/7/2019

Rochester Family Dental

Patient Info Form

Ann K. Calamel, DDS
General Dentistry

Patient Info

First Name	Last Name	Preferred Name
Date of Birth	SSN	

Address	City	Zip
Email	Cell Phone	Home Phone	Work Phone

Insurance Information

Primary Dental Insurance Provider		Employer	Insurance Provider Phone
Subscriber Name	Subscriber ID	Subscriber DOB	Group

Secondary Dental Insurance Provider (if applicable)		Employer	Insurance Provider Phone
Subscriber Name	Subscriber ID	Subscriber DOB	Group

How did you hear about us?

Form Completed By: (Print) Date * Signature *

***If completing for digitally and emailing to us, you will be asked to sign and date when you arrive at your appointment. Please leave the above fields for signature and date BLANK.**