

Thompson Dental Medical History Form

Patient Name: _____
Last First MI Preferred Name

Date of Birth: _____ SSN: _____

Email: _____ Phone: _____

Address: _____

Primary Physician Information: _____
Name Phone Number Last Visit

Do you require a **PreMed** before dental procedures? No Yes
If Yes, what antibiotic do you take? _____

Please **list any prescription or non-prescription medications**, supplements and/or vitamins you are taking below.

Do you or have you ever used tobacco? No Yes
If Yes, what type? _____
Frequency of use: _____
Cessation goals: _____

WOMEN ONLY:

Are you pregnant? No Yes
Due date: _____
Are you presently nursing? No Yes

Do you have (or have you had) any of the following diseases, problems, symptoms, or treatment? (select all that apply)

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Excessive | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Low Blood |
| <input type="checkbox"/> A-FIB | <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Heart Valve | <input type="checkbox"/> Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Gastroenteritis | <input type="checkbox"/> Replacement | <input type="checkbox"/> Macular |
| <input type="checkbox"/> Angina | <input type="checkbox"/> COPD | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Degeneration |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Gout | <input type="checkbox"/> High Blood | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Graves' Disease | <input type="checkbox"/> Pressure | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Artificial Bones | <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches | <input type="checkbox"/> HPV | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Treatment |

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other (List Below) |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Tumors | |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Venereal Disease | |
| | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> None of the above | |

Do you have any **allergies** to the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Jewelry/Metals | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthesia | <input type="checkbox"/> Other (List Below) |
| <input type="checkbox"/> Dietary Allergies | <input type="checkbox"/> Opioids (i.e. Hydrocodone, Oxycodone) | <input type="checkbox"/> No Known Allergies |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Seasonal Allergies | |
| <input type="checkbox"/> Gluten | | |

Do you have any **other health issues**? Have you had any **surgeries**? Please list them below. Include dates if possible.

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Signature: _____ Date: _____

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