Family Dental Center of Caledonia, L.L.C.

120 W. Main St. • Caledonia, MN 55921-1109 (507)725-5254

Medical History

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.

☐ *No Epi!	☐ *Pre-Med	☐ ADHD	☐ AFib
☐ Allergy: Amoxicillin	☐ Allergy: Aspirin	☐ Allergy: Codeine	☐ Allergy: Latex
☐ Allergy: Other	☐ Allergy: Penicillin	☐ Allergy: Sulfa	☐ Anemia
☐ Anxiety	☐ Arthitis/Rheumatism	☐ Artificial Joints	☐ ArtificialHeartValve
☐ Asthma	☐ Auto Immune Disease	☐ Back Problems	☐ Bipolar
☐ Blood Thinner	☐ Bone Density	☐ Brain Tumor	☐ Bypass
☐ COPD	☐ Cancer	☐ Celiac Disease	☐ Chemical Dependency
☐ Circulatory Problems	☐ Congestive Heart fai	☐ Cortisone Treatments	☐ Currently pregnant
☐ Depression	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting or dizzines	☐ GERD	☐ Glaucoma
☐ HIV	☐ Headaches	☐ Heart Attack	☐ Heart Murmur
☐ Heart Problems	☐ Hepatitis	☐ Herpes	☐ High Blood Pressure
☐ High cholesterol	☐ Hypothroidism	☐ Jaw Pain	☐ Kidney Disease
☐ Liver Disease	☐ Low Blood Pressure	☐ Lupus	☐ MS
☐ Mitral Valve Prolaps	☐ Myotonic Dystrophy	☐ Other Condition:	☐ Pacemaker
☐ Parkinsons	☐ Previous Stroke	☐ Radiation Therapy	☐ Respiratory Disease
☐ Sensory Issues	☐ Severe Kidney Damage	☐ Shortness of Breath	☐ Sinus Trouble
☐ Stent	☐ Thyroid Problems	☐ Tuberculosis	☐ Ulcer

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____

_____

_____

_____

Allergies not listed:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

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

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

☐ * **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.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

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

☐ **I do not wish to provide my email at this time.**

Response Date: _____