Buffalo Prairie Dental

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Medical History

Patient Name: _____ _____ _____ _____

Last First MI Preferred Name

Indicate which of the following conditions you have or have history of. By checking the box, it will indicate a "YES" response, leaving blank will indicate a "NO" response. This list continues onto the second page.

☐ Allergies, Drug	☐ Allergies, Anesthesia	☐ Allergies, Food	☐ Allergies, Latex
☐ Arthritis, Rheumatoid	☐ Arthritis	☐ Artificial Joints	☐ Artificial Valves
☐ Asthma	☐ Cancer, Tumor/Growth	☐ Cardiac Stent	☐ Cold Sores
☐ Heart Attack	☐ Diabetes	☐ Tuberculosis	☐ Drug/Alcohol Use
☐ Nervousness	☐ Emphysema	☐ Endocarditis	☐ Epilepsy or Seizures
☐ Fainting/Dizziness	☐ Glaucoma	☐ Head or Neck Injury	☐ Headaches/Migraines
☐ Heart Disease	☐ Heart Murmur	☐ Heart Surgery	☐ Hemophilia
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol	☐ HIV/Aids
☐ Atrial Fibrillation	☐ Hypoglycemia	☐ Anemia or Blood D/O	☐ Angina/Chest Pain
☐ Acid Reflux / GERD	☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure
☐ Lung Disease/Problem	☐ Lupus	☐ TMJ, Jaw Pain	☐ Mental Disorders
☐ Mitral Valve Prolaps	☐ Neurologic Disorders	☐ Osteo(porosis/penia)	☐ Stroke, Aneurysm
☐ Pacemaker	☐ Para/Thyroid Disease	☐ Pre-Med for Dental	☐ Prolonged Bleeding
☐ Radiation or Chemo	☐ Rheumatic Fever	☐ Scarlet Fever	☐ Sinus Problems
☐ Sleep D/O or Apnea	☐ Smoking/ Tobacco Use	☐ STI/STD	☐ Stomach Problems
☐ Weight Mgmt Meds (Phen/Fen – Redux)			

FEMALE: ☐ Taking birth control FEMALE: ☐ Nursing FEMALE: ☐ Currently Pregnant

If you selected ANY Allergies above, please list:

If you selected Osteoporosis or Osteopenia, have you ever taken medication for this, such as Biphosphonates?

If you selected any conditions or alerts above that need further clarification, please describe below:

If you take an antibiotic premedication for your dental visits, please explain:

List all medications (prescription and non-prescription) including regular doses of aspirin:

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

Name of your physician and phone number:

Name, location, and phone number of your preferred pharmacy:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. 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.**