TIMBERVIEW FAMILY DENTAL - 2400 Eastern Ave, Plymouth WI 53073 - Phone: (920) 893-5949

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

Medical History

1. Do you have a Primary Care Doctor? _____ **YES** **NO**
   - If yes, please list: _____
2. Are you presently taking any medications/drugs/pills/herbals/supplements? _____ **YES** **NO**
3. Do you smoke, chew tobacco, or use E-cigarettes? _____ **YES** **NO**
4. Are you allergic to any medications or otherwise? _____ **YES** **NO**
5. (Women) Are you pregnant or nursing? _____ **YES** **NO**
6. (Women) Are you taking oral contraceptives? _____ **YES** **NO**
7. Do you have Diabetes? _____ **YES** **NO**
   - If yes, please indicate: _____ Type 1 _____ Type 2 Last HbA1c date and level:_____
8. Do you take an antibiotic premedication for any reason? _____ **YES** **NO**
   - If yes, for what reason do you premedicate? _____
9. Please circle **YES** or **NO** if any conditions below apply to you:

Abnormal Blood Pressure	YES	NO	Eating Disorder	YES	NO	Leukemia	YES	NO
Anemia	YES	NO	Epilepsy or Seizures	YES	NO	Mental Health Disorder	YES	NO
Angina/Chest Pain	YES	NO	Fainting or Dizziness	YES	NO	Methemoglobinemia	YES	NO
Arthritis	YES	NO	Gastroesophageal Reflux (GERD)	YES	NO	Organ Transplant	YES	NO
Asthma	YES	NO	Glaucoma	YES	NO	Osteonecrosis of the Jaw	YES	NO
Bleeding Disorder	YES	NO	Head/Neck Radiation	YES	NO	Osteoporosis/Bisphosphonate Use	YES	NO
Blood Thinners	YES	NO	Heart Attack	YES	NO	Psychiatric Care	YES	NO
Cancer	YES	NO	Heart Surgery	YES	NO	Rheumatic Fever	YES	NO
Chemotherapy	YES	NO	Heart Murmur	YES	NO	Sinus Trouble	YES	NO
Cleft Lip/Palate	YES	NO	Heart Pacemaker	YES	NO	Sleep Apnea	YES	NO
Congenital Heart Defect	YES	NO	Hepatitis A, B or C	YES	NO	Stroke	YES	NO
Congestive Heart Failure	YES	NO	HIV Positive/AIDS	YES	NO	Thyroid Problem	YES	NO
Dementia	YES	NO	Kidney Problems/Dialysis	YES	NO	Tuberculosis or Lung Disease	YES	NO

10. Have you had any other serious illness, hospitalization or accident?_____ **YES** **NO**
    - If yes, please explain: _____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date: _____

Patient Signature (Parent or Guardian)

Reviewed by Doctor _____ Date: _____