Yuknis & Foster Family Dental

MEDICAL HISTORY

Patient Name: ____Date of Birth:_____________________

Mailing Adress______________________________________City/State/Zip____________________________

Home Phone______________ Work Phone_______________ Cell Phone______________________________

Email Address____

Do you prefer a phone call, email or text reminders?____

DO YOU CURRENTLY OR HAVE YOU HAD ANY OF THE FOLLOWING: (please circle)

Heart Attack High Blood Pressure Heart Disease Heart Bypass Surgery HIV

Hepatitis Diabetes Epilepsy Congenital Heart Defect Stroke Cardiac Pacemaker

Rheumatic Fever Mitral Valve Prolapse Tuberculosis Artificial Joints

Chemical Dependency Kidney/Liver Disease Cancer Glaucoma

Cold Sores (Herpes) Had Bisphosphonates for Osteoporosis (Boniva, IV, etc.)

Periodontal Disease Thyroid Disease Dental Anxiety Inflammatory Bowel Disease

I am allergic to: Penicillin____ Clindamycin_____ Sulfa_____ Other:____________________________________

Female Patients, Is it possible you are pregnant? Yes____ No______ Due Date: __________________________

When was your last dental exam? _________________________Last Dental Cleaning? ____________________

On a scale of 1-10 (10 being very happy), how happy are you with your smile? ____________________________

Additional Information about your medical history: ____

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I currently take the following medications: ____

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Do you give permission for any other person to have access to your dental information such as a spouse or parent? If yes, whom: ____

Signature____ Date: _____________________