# Caldwell,Bills, Petrilli & West

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## 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.**

- ☐ A Fib with no Epi
- ☐ Asthma
- ☐ Chemotherapy
- ☐ Coumadin
- ☐ Epinephrine Allergy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tumors
- ☐ Verapamil
- ☐ Allergies
- ☐ Blood Disease
- ☐ Clindamycin Allergy
- ☐ Diabetes
- ☐ Erythromycin Allergy
- ☐ HIV
- ☐ Heart Murmur
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Nitroglycerin
- ☐ Premed
- ☐ Rheumatoid Arthritis
- ☐ Sulfa Allergy
- ☐ Tylenol Allergy
- ☐ Vicodin Allergy
- ☐ Amoxicillin Allergy
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Hay Fever
- ☐ Hepatitis
- ☐ Latex Allergy
- ☐ MitralValve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ TMJ
- ☐ Ulcers
- ☐ Artificial Joints
- ☐ Cephalosphrins Aller
- ☐ Convulsions/seizures
- ☐ Epilepsy
- ☐ Fainting
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Lisinopril
- ☐ Morphine
- ☐ Penicillin Allergy
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Venereal Disease

☐ FEMALE: Pregnant or Planning Pregnancy ☐ FEMALE: Nursing

**If any conditions or alerts selected above need further clarification, please describe below (including due date if pregnant):**

_____
_____
_____

**Do you use Tobacco or Nicotine? If yes, check all that apply;**

☐ Smoking ☐ Chewing ☐ Vaping

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

**PRE-MED**

_____
_____

**Are you taking any medications (prescription and non-prescription) including regular doses of aspirin or birth control pills? If yes, please list below. ***

◯ Yes ◯ No

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

**Have you taken or are you taking any Bisphosphonate drug used to treat osteoporosis or Paget's disease? Examples; Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Prolia etc. If yes, please enter the drug in the Medications list above. ***

◯ Yes ◯ No

**Do you have any allergies not listed above (including allergies to medications)? If yes, please explain below *** ◯ Yes ◯ No

**ALLERGIES**

**Name and phone number of your Physician:**

**Name and phone number of preferred Pharmacy:**

**In an emergency who should be notified? Please enter Name and Phone number below:**

**Describe any current medical treatment, recent hospitalizations and recent or impending surgery.**

☐ ***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.**

******FOR EXISTING PATIENTS ONLY******
**PLEASE REVIEW AND MAKE ANY NECESSARY UPDATES**