Medical History

The Dental Office of Solon

Name of personal physician: Date of last visit:

Your current physical health is: Good / Fair / Poor Currently under a physician's care?: Yes or No

Are you allergic to any of the following?
(circle all that apply)

Aspirin	Erythromycin	Sedatives
Codeine	Jewelry	Sulfa Drugs
Latex	Penicillin	Tetracycline
Dental Anesthetics	Other	

Are you taking any of the following?
(circle all that apply)

Antibiotics	Aspirin	Blood Pressure Meds
Blood Thinners	Digitalis/Heart Meds	Insulin/Diabetes Meds
Steroids	Thyroid Meds	Tranquilizer/Anti-depressant

List any other prescription medications:

Do you have or have you experienced any of the following?
(circle all that apply)

Abnormal Bleeding	Arthritis	Artificial Bones/Joints
Artificial Valves	Asthma	Cancer
Chemotherapy/Radiation	Colitis/Krohn's	Congenital Heart Defect
Diabetes	Difficulty Breathing	Dry Mouth/Sjogren's Syndrome
Emphysema	Epilepsy/Seizures	Frequent Headaches
Heart Attack	Heart Surgery	Hepatitis
High Blood Pressure	HIV/AIDS	Kidney Problems
Liver Disease	Low Blood Pressure	Osteoporosis
Pacemaker	Rheumatic Fever	Scarlet Fever
Sinus Problems	Stroke	Thyroid Problems
Tuberculosis (TB)	Ulcers	Snoring/Sleep Apnea

List any other conditions:

1. Do you smoke or use tobacco in any form? YES / NO
2. Have you even taken Bisphosphonate drugs, such as Fosamax or Boniva? YES / NO
3. Has it ever been recommended that you take antibiotic prior to a dental visit? YES / NO

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform tis office of any changes in my medical status. I authorized the dental staff to perform the necessary dental services I may need.

Print Name: _____ Signature: _____