TED A. JOWETT
FAMILY DENTISTRY
live life smiling!

MEDICAL HISTORY

Patient Name: _____ _____ _____ _____

Last First MI Preferred Name

Please indicate if you have experienced any of the following:

- ☐ Allergies
- ☐ Pre-Med: Amoxicillin
- ☐ Pre-Med: Clindamycin
- ☐ Pre-Med: Other
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis-A
- ☐ Hepatitis-B
- ☐ Hepatitis-C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitrovalve Prolapse
- ☐ Nervous Disorders
- ☐ Osteoporosis Meds
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ OTHER

Explain Other Medical Conditions:

Primary care physician's name, address and phone number, approximate date of last visit:

What medications are you currently taking?

Are you allergic or have you reacted adversely to any of the following medications?

☐ Aspirin ☐ Latex ☐ Codeine ☐ Erythromycin ☐ Valium
☐ Penicillin ☐ Sulfa ☐ Keflex ☐ Other

Please explain any reactions here:

Have you ever taken any of the following medication?

☐ Actonel ☐ Aredia ☐ Boniva ☐ Fosamax ☐ Reclast ☐ Zometa

WOMEN ONLY: Are you pregnant?

☐ Yes ☐ No

**Do you have any other health issues or allergies?

Response Date: