Janet Mason, DDS

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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.

- ☐ AFIB
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Val
- ☐ Artificial Joints
- ☐ Aspirin Allergy
- ☐ Asthma
- ☐ Atopic (eczema)
- ☐ Augmentin Allergy
- ☐ Auto - Immune Disord
- ☐ Back Problems
- ☐ Biaxin Allergy
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cannot swallow pills
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cholesterol
- ☐ Circulatory Problems
- ☐ Codeine Allergy
- ☐ COPD
- ☐ Cortisone Treatments
- ☐ Cough Up Blood
- ☐ Cough, Persistent
- ☐ Currently Pregnant
- ☐ Defibrillator
- ☐ Dementia
- ☐ Diabetes
- ☐ Doxycycline Allergy
- ☐ Emphesyma
- ☐ Emycin Allergy
- ☐ Epigastric Pain
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Flexaril Allergy
- ☐ Food Allergies
- ☐ Gerd
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hypothyroidism
- ☐ Ibuprofen allergy
- ☐ Irregular heart beat
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Liver Transplant
- ☐ Lodine Allergy
- ☐ Low Blood Pressure
- ☐ Low Blood Sugar
- ☐ Lung disease
- ☐ Material Allergies
- ☐ Mediport
- ☐ Menier's Disease
- ☐ Mental Disorders
- ☐ MVP
- ☐ No Epi
- ☐ NSAIDS Allergy
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pain Meds Allergy
- ☐ Parkinsons Disease
- ☐ Penicillin Allergy
- ☐ Pneumonia
- ☐ Pre- Med
- ☐ Pregnant
- ☐ Psorisis
- ☐ Radiation Treatment
- ☐ Rapid Weight Change
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stents
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Surgical Implant
- ☐ Swelling of Feet
- ☐ Thyroid Disease
- ☐ Tobacco Habit
- ☐ Tonsilitus
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Z PACK Allergy

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____

_____

_____

_____

Allergies not listed:

_____

_____

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

Pre-Med:

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

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

☐ * **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.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Response Date: _____