

Franklin Family Smiles PC

www.franklinfamilysmiles.com

480 West Central Street • Franklin, MA 02038

office@franklinfamilysmiles.com

(508)528-6900

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.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Allergy - Aspirin |
| <input type="checkbox"/> Allergy - Clindamycin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa |
| <input type="checkbox"/> Allergy- Teracycline | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Premed | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Ulcers | | | |

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 and herbal supplements? 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.

Signature _____

Relationship to patient _____

Date _____
