Ben Belfiglio, DDS Leonard Yuknis, DDS Debbie Wrigley, DDS

Medical History

Patient Name: ______________________________ **Date of Birth:** ______________

Are you ALLERGIC or had an unfavorable reaction to the following:

❑ Penicillin ❑ Clindamycin ❑ Sulfa ❑ Other Antibiotic: ______________________________

❑ Novocaine or other local anesthetics: ______________ ❑ Latex ❑ Metal: ______________

❑ Any other drugs/chemicals/medications: ______________________________

Do you or have you had any of the following: ❑ Tobacco Use: ______________________________

❑ Anemia	❑ Any Surgeries	❑ Arthritis	❑ Artificial Joints
❑ Asthma	❑ Autoimmune	❑ Blood Disease	❑ Cancer – List Type
❑ Chemical Dependency	❑ Diabetes	❑ Dizzy/Fainting	❑ Dry Mouth
❑ Epilepsy	❑ Excessive Bleeding	❑ Gastric Reflux	❑ Glaucoma
❑ Hay Fever/Allergies	❑ Head Injuries	❑ Heart Attack	❑ Heart Disease/Defect
❑ Heart Murmur	❑ Heart Surgery/Valves	❑ Hepatitis/Jaundice	❑ High Blood Pressure
❑ Kidney Disease	❑ Liver Disease	❑ Mental Disorders	❑ Nervous Disorders
❑ Pacemaker	❑ Radiation/ Chemo	❑ Need Wheelchair	❑ Respiratory Problems
❑ Rheumatic Fever	❑ Rheumatoid Arthritis	❑ Sinus Problems	❑ Stomach Problems
❑ Stroke	❑ Tuberculosis	❑ Tumors	❑ Ulcers

Are you pregnant? If yes, when are you due?______________________________

Comments or anything else we should be aware of: ______________________________

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Please list any medications you are currently taking: ______________________________

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Have you ever had an unfavorable reaction to dental treatment: ______________________________

Signature: ______________________________ **Date:** ______________