Wadsworth Family Dentistry

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brushandfloss@live.com
(330) 335-2525

Patient Name: ______________________ * ______________________ * _______ ______________________

Last | First | MI | Preferred Name

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ *Pre-Med – Amox	☐ *Pre-Med – Clind	☐ Pre-Med – Other	☐ Allergies
☐ Allergy – Aspirin	☐ Allergy – Codeine	☐ Allergy – Erythro	☐ Allergy – Hay Fever
☐ Allergy – Latex	☐ Allergy – Other	☐ Allergy – Penicillin	☐ Allergy – Sulfa
☐ Anemia	☐ Artificial Heart Valve	☐ Artificial Joints	☐ Asthma
☐ Bisphosphonates	☐ Blood Disease	☐ Blood Thinners	☐ Cancer
☐ Chemical Dependency	☐ Diabetes	☐ Dizziness	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma	☐ Head Injuries
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ HIV	☐ HPV	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Anxiety/Depression	☐ Mitral Valve Prolapse	☐ Mouth Sores
☐ Neurological Disorder	☐ Other	☐ Pacemaker	☐ Pregnant or Nursing
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism/Arthritis
☐ Sinus Problems	☐ Stroke	☐ Thyroid	☐ Tobacco Use
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease/STD

Any Prosthetics, Implants, Hip, Knee, or Joint Replacements? If so, please indicate what and when:

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Any Heart Conditions, Stents, Valves, or Pacemakers? If so, please indicate what and when:

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Do you have a sore throat, hoarseness, ear ache, or feeling like something being caught in your throat? * ◯ Yes ◯ No

PRE- MED patients: please list why Pre-Med is needed: ____________________________

If any conditions or alerts selected above needs further clarification, or a condition is not listed please describe below. Also include if there have been any medical changes or hospitalizations since your last visit with us.

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List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

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☐ *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had 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.

Response Date: ______/______/______