Hoekwater Family Dentistry, P.C.

www.hoekwaterdental.com
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Medical History

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

Date of Birth: _____

What is your estimate of your general health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

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.

☐ ADD/ADHD	☐ Allergies	☐ Allergy Amoxicillin	☐ Allergy Anesthetic
☐ Allergy Clindamycin	☐ Allergy Keflex	☐ Allergy Latex	☐ Allergy Penicillin
☐ Allergy Sulfa	☐ Alzheimer's/Dementia	☐ Anemia	☐ Anxiety
☐ Arthritis	☐ Artif Joint-nopremed	☐ Artificial Joints	☐ Asthma
☐ Autism	☐ Auto immune disease	☐ Blood thinners	☐ Bone Density Meds
☐ Bulimia	☐ Cancer	☐ Dental anxiety	☐ Diabetes
☐ Dizziness/Fainting	☐ Downs Syndrome	☐ Epilepsy	☐ Epinephrine sens
☐ Excessive Bleeding	☐ Glaucoma	☐ Hay Fever	☐ Hearing impairment
☐ Heart attack	☐ Heart defect	☐ Heart Disease	☐ Heart Murmur
☐ Heart Transplant	☐ Hemophilia	☐ Hepatitis A B or C	☐ High Blood Pressure
☐ HIV/AIDS	☐ Joint Repl w/PreMed	☐ Kidney disease	☐ Leukemia
☐ Liver Disease	☐ Low blood pressure	☐ Medication Allergy	☐ Mental Disorders
☐ Migraines	☐ Mitral Valve	☐ Mitral Valve PreMed	☐ Multiple Sclerosis
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Radiation/Chemo
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Seizures	☐ Sinus Problems
☐ Sleep Apnea	☐ Smoker/Tobacco use	☐ Stroke	☐ Tuberculosis
☐ Ulcers	☐ Vertigo	☐ Visual Impairment	

FEMALES ONLY:
☐ Taking contraceptives ☐ Using Hormone Replacement Therapy
☐ Pregnant or planning pregnancy ☐ Nursing

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____

_____

Do you have any allergies not listed above (including allergies to medications)? If yes, please list below:

_____

_____

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please list medication below: ○ Yes ○ No

PRE MED:

Name of your physician and your most recent physical exam:

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

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

Name and phone number/location of your preferred pharmacy:

☐ **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 I must notify the practice of any future changes.**

Signature _____ **Date** _____

Response Date: _____