Adam Diesburg, DDS
DENTISTRY

Patient Medical History

Last Name First Middle

Birthdate _____ Age _____ M / F

Allergies

Mark all medications or health care related substances to which you have experienced an allergic or adverse reaction:

- ☐ Penicillin
- ☐ Codeine
- ☐ Latex
- ☐ Sulfa drugs
- ☐ Epinephrine
- ☐ Local Anesthetics
- ☐ Others _____
- ☐ None

Medications

List all medications and dietary supplements you have taken in the last 3 months. If known, include dosage and reason for taking the medication.

Are you currently under a physician's care? Yes No If so, for what reason? _____

Physician's Information _____
Dr's Name Address City State Zip Phone

Please mark any of the following you may have had, or have at present

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Congenital Heart Disease
- ☐ Artificial Heart Valve
- ☐ Pacemaker
- ☐ High / Low Blood Pressure
- ☐ Heart Attack or Heart Disease
- ☐ Blood thinning treatment
- ☐ HIV or AIDS
- ☐ Hepatitis or Liver Disease
- ☐ Venereal Disease
- ☐ Inner Ear disorders or Surgery
- ☐ Artificial Joint
- ☐ Surgical Prosthesis
- ☐ Ulcers/Stomach problems
- ☐ Cancer or related treatment
- ☐ Kidney trouble
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Scarlet Fever
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Arthritis / Rheumatism
- ☐ Stroke
- ☐ Epilepsy or seizures
- ☐ Fainting or dizzy spells
- ☐ Psychiatric treatment
- ☐ Leukemia
- ☐ Bruise easily
- ☐ Asthma
- ☐ Hay Fever
- ☐ Emphysema
- ☐ Allergies or Hives
- ☐ Sinus trouble
- ☐ Cold sores or herpes
- ☐ Other _____

Have you ever been requested to take antibiotics or other medications before a dental appointment? Yes No
Is there anything else we should know about your health that is not covered in this form? Yes No
Would you like to speak with the doctor privately about any matter? Yes No

For women only-

Are you pregnant? Yes No
Are you nursing? Yes No
Do you take birth control? Yes No

Do you or have you used:

Tobacco Yes No
Alcohol Yes No
Illegal IV drugs Yes No
☐ Other _____

I certify that the above information is complete and accurate

_____ _____
Patient / Guardian Signature Date