Erskine Family Dentistry
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## Patient Medical History

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

**Please check if you have ever had:**

- ☐ Stroke
- ☐ Blood Clotting Disorder
- ☐ Heart Ailment
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Artificial Heart Valves
- ☐ Infective Endocarditis
- ☐ Total Joint Implants
- ☐ Pins/Plates/Screws
- ☐ HIV/AIDS
- ☐ Donor Organs
- ☐ Head/Jaw Injury
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Liver Disease
- ☐ Hepatits/Yellow Jaundice
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Stomach/Intestinal Disease
- ☐ Reflux
- ☐ Sexually Transmitted Disease
- ☐ Other
- ☐ Respiratory Disease
- ☐ Asthma
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Tumor/Cancer
- ☐ Radiation TREATMENTS
- ☐ Chemotherapy
- ☐ Thyroid Problems
- ☐ Rheumatism/Arthritis
- ☐ Osteoporosis Treatment
- ☐ Snore/Sleep Apnea

**Please check if you have any of the following allergies/sensitivities:**
☐ Latex ☐ Nickel/Jewelry ☐ Penicillin ☐ Codeine ☐ Sulfa

**Other**

_____

_____

**Do you use tobacco?** ○ Yes ○ No

**If yes, which of the following**
☐ Cigarettes ☐ Chewing Tobacco ☐ Cigars

**How long/Use per day**

_____

_____

**Do you now have, or have you had, a chemical dependency? *** ○ Yes ○ No

**If yes, are you in recovery?** ○ Yes ○ No

**How long have you been in recovery?** _____

**For Women Only**
☐ Birth Control Pills ☐ Pregnant ☐ Nursing

**If pregnant, due date** _____

**Are you under medical treatment or have you had any major operations in the past 5 years?**

**Alerts**

**Current Medications, Dosage & Purpose:**

**Physician's Name & Phone Number**

**Response Date:**
____/____/_____