Rowan Family Dentistry

www.rowanfamilydentistry.com
rowandentistry@gmail.com
730 Coulter Drive • New Albany, MS 38652
(662)534-4397

Medical History

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

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.

- ☐ 3% Only no Epi
- ☐ Actonel
- ☐ Allergies
- ☐ Allergy Codiene
- ☐ Allergy Latex
- ☐ Allergy Penicillin
- ☐ Anemia
- ☐ Anti Depressant
- ☐ Aredia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting problems
- ☐ Fosamax
- ☐ Glaucoma
- ☐ HBP
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High BP
- ☐ HIV AIDS
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Kidney/Bladder issue
- ☐ LBP
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Pre-Med
- ☐ Radiation Therapy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ See Pt Note
- ☐ Shortness of Breath
- ☐ Sinus trouble
- ☐ Stroke
- ☐ TB
- ☐ Venereal Disease
- ☐ Zometa

☐ Ever been hospitalized (illness or injury) ☐ FEMALE: Taking birth control pills ☐ FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

_____
_____
_____
_____

Allergies (Please list all Allergies below):

_____
_____
_____
_____
_____
_____
_____
_____

Have you had any of the following conditions which require premedications for your dental care? If yes, please Explain below:

☐ Joint replacement ☐ Artificial heart valve ☐ Endocarditis ☐ Rheumatic fever ☐ Other

Name of your physician and phone number:

_____
_____

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Medications:

_____

_____

_____

_____

☐ * **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 that I must notify the practice of any future changes. This will serve as my electronic signature.**

Response Date: ____/____/_____