Robson Family Dentistry LLC
240 E SANDUSKY AVE
Bellefontaine, OH 43311
(937)599-6115
jonathon@robsonfamilydentistry.com

Patient Name: Last | First | MI | Preferred Name

Medical History

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	☐ Allergy - Aspirin
☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Hay Fever	☐ Allergy - Latex
☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Anemia
☐ Arthritis	☐ Artificial Joints	☐ Asthma/COPD	☐ Blood Disease
☐ Blood Thinners	☐ Cancer	☐ Diabetes Type I or I	☐ Dizziness/Fainting
☐ Epilepsy/Seizures	☐ Excessive Bleeding	☐ Glaucoma	☐ Head/Neck Injuries
☐ Heart Attack/Stroke	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis A_B_C
☐ High Blood Pressure	☐ HIV/AIDS	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Mental Disorders	☐ Nervous Disorders	☐ Other
☐ Pacemaker/Stents	☐ Pregnancy	☐ Radiation/Chemo	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems	☐ STD/HPV
☐ Stomach Problems	☐ Tuberculosis	☐ Tumors/Growths	☐ Ulcers

☐ Recent Hospitalization (illness or injury)	☐ Subject to frequent headaches or migraines
☐ Presently being treated for any other illness	☐ Tobacco/Alcohol Use
☐ Pregnant/Planning Pregnancy	☐ Nursing
☐ Diagnosed with Osteoporosis	☐ Taking birth control

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

Do you take antibiotic premedication for your dental visits? If yes, please explain.

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Name of physician and date of last physical exam

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

List all medications (prescription and non-prescription), including regular dosages of aspirin.

Please list any allergies and/or allergies to 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.

Name of patient, parent, or guardian completing this form:

*

Relationship to patient:

*

Response Date: 10/11/2016