240 E SANDUSKY AVE
BELLEFONTAINE, OH 43311
(937)599-6115
frontdesk@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 Etythro	☐ Allergy –Hay Fever	☐ Allergy - Latex
☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Anemia
☐ Arthritis	☐ Artificial Joints	☐ Asthma/COPD	☐ Blood Disease
☐ Birth Control	☐ Blood Thinners	☐ Cancer	☐ Diabetes Type I or II
☐ Dizziness	☐ Epilepsy/Seizures	☐ Excessive Bleeding	☐ Glaucoma
☐ HIV/AIDS	☐ Head/Neck Injuries	☐ Headaches/Migraines	☐ Heart Attack
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis A_B_C	☐ High Blood Pressure
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Nervous Disorders	☐ Nursing	☐ Osteoporosis	☐ Other
☐ Pacemaker/Stents	☐ Pregnancy - past	☐ Pregnancy - current	☐ Radiation/Chemo
☐ Recent Hospitalization	☐ Recreational Drug Use	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ STD/HPV	☐ Stomach Problems
☐ Tobacco/Alcohol Use	☐ Tuberculosis	☐ Tumors/Growths	☐ Ulcers

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

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

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More questions on Reverse

Name of physician and date of last physical exam:

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

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

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Please list any allergies and/or allergies to medications.

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☐ ***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.**

Name of patient, parent, or guardian completing this form – relationship to patient if other than "self"

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Signature:____ **Response Date:**__________________