Lowell Tooth Docs
59 Lowes Way
Suite 202
Lowell MA 01851

(978)454-8400

www.lowelltoothdocs.com
info@lowelltoothdocs.com

Confidential Medical History

Patient Name:* Last * First MI Preferred Name

Medical Conditions- Please select/verify to indicate if you have had any of the following:

- ☐ *EPI Sensitivity
- ☐ Acid Reflux
- ☐ Allergy-Aspirin
- ☐ Allergy-Erythro
- ☐ Allergy-Penicillin
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Heart Valve Replaced
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Respiratory Problems
- ☐ Thyroid Disease
- ☐ *Pre-Med - Amox
- ☐ ADD/ADHD
- ☐ Allergy-Clindamycin
- ☐ Allergy-Hay Fever
- ☐ Allergy-Sulfa
- ☐ Arthritis/Rheumatism
- ☐ Autism
- ☐ Cancer/Tumors
- ☐ Cortisone Treatments
- ☐ Drug Addiction Hx
- ☐ Head/Facial Trauma
- ☐ Hepatitis
- ☐ Jaw Pain
- ☐ Pacemaker
- ☐ Stroke
- ☐ Tuberculosis
- ☐ *Pre-Med - Other
- ☐ Allergy - Other
- ☐ Allergy-Codeine
- ☐ Allergy-LATEX
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ Chemo/Radiation
- ☐ Daily Aspirin Use
- ☐ Epilepsy
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Psychiatric Care
- ☐ Swollen Ankles/Feet
- ☐ z OTHER NOT LISTED

Clarify any of the above medical conditions or list any additional medical conditions or ALLERGIES. Has there been any change in your general health within the past year?

*

Have you had any problems with previous dental work such as prolonged numbness, sensitivity to epinephrine, or difficulty getting numb?

*

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MEDICATIONS: Are you taking or have you recently taken any prescription or over-the-counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations, and/or dietary supplements:

MEDICATION PURPOSE

*

Physician (Name, Location, Phone)

Date of last physical exam:

Are you taking or scheduled to begin taking any medications for osteoporosis? (ex: Fosamax, Boniva, Reclast)

*

Do you currently use or have you ever used tobacco (smoking, snuff, chew)? If yes, please describe type, how often, and amount.

*

Have you had an orthopedic total joint (hip, knee, elbow, finger, other) replacement or a Heart Valve Replacement? If yes, has your doctor recommended that you premed prior to dental appointments? If yes, what antibiotic do you take?

*

WOMEN ONLY - Check if any of the following apply:

- [ ] Pregnant
- [ ] Nursing
- [ ] Taking Birth Control Pills
- [ ] Taking Hormone Replacement

Response Date: