*Bremen Family Dentistry P.C.*

1712 W. Plymouth St. • Bremen, IN 46506 • Phone: (574) 546-2851 or (800) 445-9864

# PATIENT MEDICAL HISTORY FORM

Patient Name: ______________________________ Birth Date: ____________

Patient Address: ______________________________ City: ____________

Home Phone: ____________ Cell Phone: ____________ Work: ____________

E-mail Address: ______________________________

**HAS THE ABOVE INFORMATION CHANGED SINCE THE LAST TIME YOU WERE HERE?** Yes ___ No___

**HOW WOULD YOU PREFER WE CONFIRM APPOINTMENTS:**

Phone: ____________ Text Message: ____________

E-mail: ______________________________

Family Physician: ______________________________ Physician's Phone: ____________

Circle any of the following which you currently have or have had in the past:

| | | | |
|---|---|---|---|
| Heart Murmur | Rheumatic Fever | Mitral Valve Prolapse | Heart Attack |
| Pacemaker | Heart Pain (angina) | Fainting/Dizzy Spells | High Blood Pressure |
| Stroke | Artificial Heart Valve | Heart Surgery | Hepatitis |
| Diabetes | Anemia/Hemophilia | Kidney Trouble | Alcoholism/Drug Addiction |
| Artificial Joint | Radiation Therapy | Cancer/Tumor | Chemotherapy |
| Arthritis | Asthma | Cold Sores | Epilepsy/Seizures |
| TMJ | Psychiatric Treatment | AIDS | Venereal Disease |

Do you have any diseases, conditions, or problems not listed above? YES NO

IF YES, please list: ______________________________

Are you presently taking any prescription medications? YES NO

IF YES, please list medication name, dosage, and frequency: ______________________________

Are you presently taking any herbs or nonprescription medications? YES NO

IF YES, please list medication name, dosage, and frequency: ______________________________

Are you allergic to any medicine, drug, **LATEX**, or other substance? YES NO

IF YES, please list: ______________________________

Have you been under the care of a physician within the last two years? YES NO

Have you had surgery within the last six months? YES NO

IF YES, list date and type: ______________________________

Has a physician ever told you to premedicate before having dental procedures done? YES NO

Have you ever had unusual or uncontrolled bleeding? YES NO

Are you taking aspirin or a blood thinner on a regular basis? YES NO

Have you ever had complications or an illness following dental treatment? YES NO

Have you ever had an injury or trauma to your face or jaw? YES NO

IF YES, list date and event: ______________________________

Do you smoke or use smokeless tobacco? YES NO

Are you nervous or concerned about having dental work done? YES NO

Would you like to have a fluoride treatment after your teeth cleaning? YES NO

WOMEN: Are you, or could you be, pregnant? YES NO Due Date: ____________

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X ______________________________ ____________

PATIENT, PARENT OR GUARDIAN DATE