Everson Dental Clinic

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(360)966-7777

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.

☐ Artificial heart valve	☐ Atrial fibrillation	☐ Heart attack	☐ Heart disease	☐ Pacemaker	☐ Stroke
☐ Blood thinners	☐ High blood pressure	☐ Excessive bleeding	☐ Tachycardia	☐ Hepatitis	☐ Liver disease
☐ Diabetes	☐ Autoimmune disorder	☐ Asthma	☐ Respiratory problems	☐ COPD	☐ Tuberculosis
☐ Acid reflux	☐ Cancer	☐ High cholesterol	☐ Lupus	☐ Epilepsy	☐ HIV/AIDS
☐ Kidney disease	☐ Artificial joints	☐ Glaucoma	☐ Arthritis	☐ Sinus problems	☐ Mental illness
☐ Depression/anxiety	☐ Eating disorders	☐ Allergy to penicillin	☐ Allergy to latex	☐ Smoking/tobacco use	☐ Drug addiction
☐ Thyroid					

Notes

_____

_____

_____

_____

_____

Do you have allergies to anything else that is not listed?

_____

_____

Medical History

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

_____

_____

Have you had an orthopedic total joint replacement (hip,knee,elbow,finger), if so, please describe below. Please include any complications from procedure:

_____

_____

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

_____

_____

Have you taken or received oral or IV bisphosphonates for osteoporosis or other bone disorders (i.e. Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)

◯ Yes ◯ No

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

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

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

Name of your physician:

Name of your preferred pharmacy:

FEMALES ONLY:

☐ Taking contraceptives/birth control ☐ Using Hormone Replacement Therapy ☐ Pregnant or planning pregnancy

☐ Nursing

☐ * **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: ____/____/_____