FREYER DENTAL

Medical History

Last Name: ______________________ First Name: ______________________

Name of Medical Doctor: ______________________________ City/State: ______________________

List all medications that you take:
If you take no medications write"None"

1 ______________________
2 ______________________
3 ______________________
4 ______________________
5 ______________________
6 ______________________
7 ______________________
8 ______________________
9 ______________________
10 ______________________
11 ______________________
12 ______________________
13 ______________________

Are you allergic to anything? ☐ Yes ☐ No

Please mark whether or not you have the following allergies.

Y	N	
☐	☐	Local Anesthetics
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Ibuprofen, naproxen or NSAIDS
☐	☐	Iodine
☐	☐	Latex
☐	☐	Penicillin or Amoxicillin
☐	☐	Sulfa
☐	☐	Morphine
☐	☐	Keflex or other Cephalosporins
☐	☐	Other Drug Allergies
☐	☐	Other Food or Environmental Allergies

Have you ever taken:

	Y
Fosamax (alendronate), Boniva (ibandronate), or Actonel (risendronate) for osteoporosis or Paget's Disease?	☐
IV bisphosphonates (Aredia or Zometa) for diseases like multiple myeloma, metastatic cancer, or Paget's disease?	☐

Do you have any of the following medical conditions?

Y	N	
☐	☐	Asthma
☐	☐	Bleeding Problems
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Heart Murmur
☐	☐	Heart Attack
☐	☐	High Blood Pressure
☐	☐	Heart Failure
☐	☐	Artificial Heart Valves
☐	☐	Irregular heartbeat or palpitations
☐	☐	COPD or other Lung Disease
☐	☐	Tobacco or Vape Use
☐	☐	Smoke Other Drugs
☐	☐	Pacemaker or Defibrillator
☐	☐	Radiation treatment
☐	☐	Pregnant Now / Could Possibly be Pregant

Y	N	
☐	☐	Kidney Disease
☐	☐	Kidney Failure or Dialysis
☐	☐	Liver Disease
☐	☐	Hepatitis
☐	☐	Sinus Trouble
☐	☐	Stroke
☐	☐	Ulcers
☐	☐	Rheumatic Heart Disease
☐	☐	Sleep Apnea or gasp for air when sleeping
☐	☐	Family or personal problem with anesthesia
☐	☐	Thyroid Disease
☐	☐	Skin Disease
☐	☐	Arthritis
☐	☐	Back Problems
☐	☐	Psychiatric Treatment
☐	☐	Other Health Problems

If tobacco use, what kind and how much?______________________

Unusual reaction to dental injections? ______________________

Reason for today's visit ______________________ Are you in pain? ______________________

New patients:

Do you have x-rays available for your visit today? ______________________

When was your last dental visit? ______________________