DENTAL BY NATURE

2120 17th Ave
Longmont, CO 80501
Tel: (303) 776-6021

MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Physician's Name and Address: _____

Has your medical Dr. informed you that a antibiotic pre-medication is needed before your dental appointment: YES NO

NEW PATIENTS PLEASE CALL OUR OFFICE AND INFORM STAFF PRIOR TO YOUR APPOINTMENT (303) 776-6021

Are you currently in pain? If so, please describe _____

How is your general health? _____

Recent serious illness? _____ Hospitalized?_____

Please list current drugs, medications, or supplements being taken: _____

_____

Please list allergies to drugs or medications: _____

Concerning diet: Do you have any food or herb allergies? _____

Do you have any allergies to metals in jewelry? _____

Do you have or have you had: (Please check all that apply)

____ Heart Trouble	____ Stroke	____ Lung Disease	____ High Blood Pressure
____ Chest Pain	____ Hepatitis	____ Low Blood Pressure	____ Diabetes
____ Cancer	____ Heart Murmur	____ Excessive Thirst	____ Artificial Joints
____ Rheumatic fever	____ Seizures	____ Hypoglycemia	____ Other Heart Problems
____ Kidney Trouble	____ Hemophilia	____ Arteriosclerosis	____ Ulcers
____ Shortness of Breath	____ Allergies	____ Addictions	____ Asthma
____ Cold Sores	____ Tuberculosis	____ Swelling Extremities	____ Sinus Problems
____ Fainting	____ Dizziness	____ HIV Positive	____ AIDS Positive
____ Vegetarian Diet	____ Thyroid Disease	____ Chronic Fatigue	____ Fibromyalgia
____ Lyme's Disease	____ Lupus	____ Muscular Sclerosis	____ Arthritis
____ Parkinson's Disease			

Other: _____

Do you snore? _____ Do you have sleep apnea? _____

Women Only: Are you pregnant? _____ Are you breastfeeding? _____

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____