Stratford Family Dental
2261 Broadbridge Avenue
Stratford, CT 06614-3860

SmileatLast.com

(203)375-4633

Clinic@StratfordCTFamilyDental..com

Medical History

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.

- ☐ *PRE-MED
- ☐ Allergies/Hay Fever
- ☐ Allergy-Codeine
- ☐ Allergy-other drugs
- ☐ Allergy-Penicillin
- ☐ Allergy-Sulfa
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Pressure-High
- ☐ Blood Pressure-Low
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Ear Noise
- ☐ Emphycema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Bypass
- ☐ Heart Conditions
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A or B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ MVP
- ☐ Nervous Disorders
- ☐ OTHER
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers

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

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

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Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Please list all allergies to food, drugs or substances:

☐ Ever been hospitalized (illness or injury)
☐ Subject to frequent headaches
☐ FEMALE: Taking birth control pills
☐ Presently being treated for any other illnesses
☐ Tobacco/Alcohol Use
☐ FEMALE: Pregnant

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

Have you traveled out of the country in the past 6 months? If so, please indicate when and where.

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

List all medications (prescription and non-prescription) including regular doses of aspirin:

* ☐ 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.

Signature_____

Response Date: _____