FRICK & JONES, P.A.
practice limited to periodontics

MEDICAL INFORMATION

Patient Name:______________________Date of Birth:______________Medical Doctor Name:______________________

Do you have a medical condition that requires you to have antibiotic premedication prior to dental procedures? yes or no

Do you now or have your ever taken medication for osteoporosis? yes or no If yes: medication name ______________________

❑ List all medications you take (including aspirin & supplements):

NAME OF MEDICATION and DOSE	NAME OF MEDICATION and DOSE

❑ Are you allergic to or do you suffer ill effects from any of the following?

Yes	No		Yes	No		Yes	No	
___	___	Penicillin	___	___	Codeine	___	___	Dental Anesthesia
___	___	Aspirin	___	___	Latex	___	___	Other: ______________________

❑ Date of last Physical Exam:_____/_____/_____

❑ Are you now or have you recently been under a physician's care? If Yes, Explain ______________________

❑ Have you been admitted to the hospital or been seriously ill in the last five years? Explain ______________________

❑ Do you use tobacco products? Circle those that you use: Cigarettes Cigars E-cigs/Vapes Smokeless tobacco

❑ Do you or a family member have diabetes? Who? ______________________

Check any of the following that you have had:

Yes	No		Yes	No		Yes	No	
___	___	Arthritis	___	___	Hepatitis or Jaundice	___	___	Prolonged Bleeding
___	___	Rheumatic Fever	___	___	Liver Disease	___	___	Fainting Tendency
___	___	Heart Trouble	___	___	Cancer or Tumor	___	___	Epilepsy
___	___	Heart Murmur	___	___	Chemotherapy	___	___	Thyroid Disease
___	___	Pace Maker	___	___	Tuberculosis	___	___	Glaucoma
___	___	Chest Pain (Angina)	___	___	Diabetes	___	___	Radiation Treatment
___	___	Stroke	___	___	Kidney/Bladder Trouble	___	___	Mental Disorders
___	___	Shortness of Breath	___	___	Anemia	___	___	HIV or Aids
___	___	High/Low Blood Pressure	___	___	Lung Disease	___	___	Prosthetic Joint Replacement
___	___	Asthma/Hay Fever	___	___	Venereal Disease	___	___	Blood Transfusion
___	___	Cortisone/Steroids	___	___	Sinus Trouble	___	___	Blood Disease

Women:

❑ Are you pregnant? yes or no
❑ Are you breast feeding? yes or no
❑ Do you take birth control medication? yes or no

I certify that the above information is correct:______________________Date: ______________
Patient Signature

______________________/______________________
Parent/Guardian Signature Relationship to Patient