Wayland Family Dental Center

Personal Health Information

Please indicate previous and current medical conditions:

□ Allergy to any medicines _____

□ Allergy to latex or any other material _____

□ Blood diseases _____

□ Heart conditions listed below:

Prosthetic cardiac valves _____

Infective endocarditis _____

Cardiac transplant _____

Congenital heart disease (repairs made with shunts or other prosthetic material) _____

□ Cancer _____

Radiation therapy? □ Yes □ No Chemotherapy? □ Yes □ No

□ Diabetes Last tested blood sugar level_____mg/dl date of last test _____

□ Epilepsy

□ Gastrointestinal conditions _____

□ History of Infectious disease (HIV, Hepatitis, TB etc…) _____

□ Joint replacement therapy_____date_____

Premedication advised prior to dental procedures? □ Yes □ No

□ Kidney or Liver disease _____

□ Musculoskeletal conditions or injuries / Jaw pain _____

□ Osteoporosis

History of medicine to treat? (Actonel, Boniva, Fosamax, Reclast) □ Yes □ No

□ Psychological conditions _____

□ Respiratory conditions / Sleep apnea / Snoring ___ _____

□ Sinus difficulties

□ Stroke date of stroke _____

□ Any other conditions or diseases not listed _____

_____

Physician Information

Primary Care Physician:

Name _____

Number _____

Location _____

Specialist:

Name _____

Number_____

Location _____

Please list all medicines you are currently taking

℞ _____

℞ _____

℞ _____

℞ _____

℞ _____

℞ _____

Patient signature _____ Date _____