Circle Drive Dental, PA
2633 Superior Dr. NW Suite 200
Rochester, MN 55901-8395

(507)289-2055
info@circledrivedental.com
www.circledrivedental.com

MEDICAL HISTORY

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

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

☐ Acid Reflux	☐ Allergy- Amoxicillin	☐ Allergy- Aspirin	☐ Allergy- Codeine
☐ Allergy- Latex	☐ Allergy- Metals	☐ Allergy- Other	☐ Allergy- Penicillin
☐ Allergy- Seasonal	☐ Allergy- Sulfa	☐ Allergy-Clindamycin	☐ Allergy-Erythromycin
☐ Allergy-Iodine	☐ Alzheimers	☐ Anemia	☐ Arthritis
☐ Artificial joints	☐ Asthma	☐ Blood Thinners	☐ Cancer
☐ Chemical Dependency	☐ Chemo / Radiation	☐ Depression	☐ Diabetes
☐ Emotional Problems	☐ Epilepsy/Seizure	☐ Excessive bleeding	☐ Glaucoma
☐ Heart disease	☐ Heart murmur	☐ Heart Problems	☐ Hepatitis
☐ High Blood Pressure	☐ High Cholesterol	☐ HIV	☐ Jaundice
☐ Kidney disease	☐ Liver disease	☐ Low blood pressure	☐ Mental disorders
☐ Migranes	☐ Mitral Valve Prolpse	☐ Nervous disorders	☐ Pacemaker
☐ Pre-Med	☐ Respiratory Problems	☐ Rheumatic fever	☐ Rheumatism
☐ Sinus Problems	☐ Sleep Apnea	☐ Stroke	☐ Thyroid disorder
☐ Tuberculosis	☐ Vertigo / Dizziness		

If none of the above applies, please mark "None" here:

☐

Any other disease or condition not listed?

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Are you planning on having any medical procedure or surgery completed in the next 6 weeks?

* ◯ Yes ◯ No

If yes: Please list Procedure, Physicians name and Date to be completed.

Have you ever had a partial or full joint replacement?

* ◯ Yes ◯ No

If yes: Please list Joint replaced, Surgeon's name, and Date of surgery.

Have you ever taken a Bisphosphonate: Actonel, Boniva, Fosamax, Didronel, or Reclast.

* ◯ Yes ◯ No

Do you ever have chest pains or trouble breathing?

* ◯ Yes ◯ No

Do you use any tobacco products?

* ◯ Yes ◯ No

If yes: What type, how much/how often, and how long have you used for?

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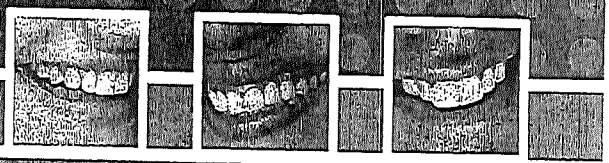

Please list any Surgeries, Operations, Hospitalizations, or Emergency Room visits you have had within the last 5 years.

WOMEN ONLY: Are you pregnant?

* ◯ Yes ◯ No

List ALL MEDICATIONS, SUPPLEMENTS and VITAMINS you are currently taking and the Reason you are taking them.

*

Parent/Guardian Signature:

*must be dated the day of the appointment.

Response Date: