Bardill Dental Associates, S.C.

bardilldental.com info@bardilldental.com

900 Sixth St N Ste 200 • Hudson, WI 54016 (715)386-5888

Patient Name:

Last ____________ First ____________ M ____

Preferred Name ____________

Medical History

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.

- ☐ Abnormal Bleeding
- ☐ Acid Reflux
- ☐ ADHD
- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Amoxicillin
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asprin
- ☐ Asthma
- ☐ Atrial Fibulation
- ☐ Augmentin
- ☐ Autism
- ☐ Autistic/Aspergers
- ☐ Autoimmune Disease
- ☐ Bipolar
- ☐ Bisphosphonates
- ☐ Blood Disorder
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cholesteral
- ☐ Chronic Bronchitis
- ☐ Clindamycin
- ☐ Codeine
- ☐ Congential Heart
- ☐ Congestive Heart
- ☐ COPD
- ☐ Coronary Artery Dis
- ☐ Damaged Heart Valves
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Dialysis
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Seizures
- ☐ Fibromyalgia
- ☐ Gastrointestinal Dis
- ☐ GERD/Heatburn
- ☐ Glaucoma
- ☐ Headaches/Migraines
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ HeartValve Replace
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High BP
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Ibuprofen
- ☐ Infective Endocard
- ☐ Iodine
- ☐ Joint Replacement
- ☐ Keflex
- ☐ Kidney Disease
- ☐ Latex
- ☐ Learning disorders
- ☐ Liver disease
- ☐ Local Anesthetics
- ☐ Low BP
- ☐ Meds Allergy
- ☐ Mental Health Dis
- ☐ Metals
- ☐ MitralValve Prolapse
- ☐ Motrin
- ☐ Myasthenia Gravis
- ☐ NeurologicalDisorder
- ☐ Operations
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Penicillin
- ☐ Pregnancy
- ☐ Pre-Med
- ☐ Prostate
- ☐ Radiation
- ☐ Respiratory Problems
- ☐ RheumaticHeart/Fever
- ☐ Rheumatoid Arthritis
- ☐ Sinus Trouble
- ☐ Sjogren's Syndrome
- ☐ Sleep Disorders
- ☐ Sores/Ulcer in mouth
- ☐ STD
- ☐ Stroke
- ☐ Sulfa
- ☐ Systemic Lupus
- ☐ Thyroid Disorders
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Weight Loss

- ☐ Ever been hospitalized (illness or injury)
- ☐ Presently being treated for any other illnesses
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Taking dietary supplements
- ☐ Subject to frequent headaches
- ☐ A smoker or smoked previously

FEMALES ONLY:

- ☐ Taking contraceptives
- ☐ Using Hormone Replacement Therapy
- ☐ Pregnant or planning pregnancy
- ☐ Nursing

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

____

____

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

____

____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and your most recent physical exam:

____

____

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

____

____

Have you had an orthopedic total joint replacement (hip,knee,elbow,finger), if so, please describe below. Please include any complications from procedure:

____

____

____

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

____

____

____

Name and phone number of your preferred pharmacy:

____

____

☐ * **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.**

Patient Information

Response Date: ____________