Dr. Frederick Stange and Associates

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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	☐ Allerg Piperacillin	☐ Allergy Antibiotic	☐ Allergy Augmentin
☐ Allergy Bactrim	☐ Allergy Clavulanic	☐ Allergy Clindamycin	☐ Allergy Codeine
☐ Allergy Doxycycline	☐ Allergy EPI	☐ Allergy Epinepherine	☐ Allergy Erythromycin
☐ Allergy Fluoride	☐ Allergy Ibuprofen	☐ Allergy Iodine	☐ Allergy Lactose
☐ Allergy Latex	☐ Allergy Levofloxacin	☐ Allergy Lidocaine	☐ Allergy Morphine
☐ Allergy NSAIDS	☐ Allergy Naproxen	☐ Allergy Novicane	☐ Allergy Nuts
☐ Allergy Pen/ Amox	☐ Allergy Prednisone	☐ Allergy Sesame	☐ Allergy Shell Fish
☐ Allergy Sulfa	☐ Allergy Tetracycline	☐ Allergy Z Pak	☐ Allergy to Aspirin
☐ Atrail Fibrillation	☐ HIV+/AIDS	☐ Headache/Jaw Pain	☐ Heart Murmur
☐ Heart Murmur Organic	☐ Heart Surgery	☐ Hemophilia	☐ Hepatitis
☐ Hepatitis A	☐ Hepatitis B	☐ Joint Replace/Pins	☐ Kidney Disease
☐ Liver Disease	☐ Low Blood Pressure	☐ Mental Disorders	☐ Mitral Valve Prolaps
☐ Nervous Disorders	☐ Pacemaker	☐ Pregnancy	☐ Radiation/Chemo
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ STD
☐ Sinus Problems	☐ Smoke/ Vape	☐ Stomach Problems	☐ Stroke
☐ Tuberculosis	☐ Tumors	☐ Ulcers	

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

____
____
____
____
____

Allergies not listed:

____
____
____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ○ Yes ○ No

Pre-Med:

____
____

Name of your Physician and Phone Number:

____

____

Preferred Pharmacy and Phone Number:

____

____

How would you rate the condition of your mouth? *

☐ Excellent ☐ Good ☐ Fair ☐ Poor

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

____

____

____

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

○ Yes ○ No

Please list any medications you are currently taking, one medication per line:

____

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☐ ***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.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ ____________________ ___ ____________________
Last First MI Preferred Name

Title: __________ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **Prev. Visit:** __________ **Email Address:** ______________________________

Phone: __________ __________ __________ ______ **Best time to call:** ______________
Home Mobile Work Ext

Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Response Date: ____________