Dr. Rita A. Tempel and Associates
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Medical History Form

Patient Name: ______ (Last) ______ (First) ___ (MI) ______ (Preferred Name)

Name and Phone Number of Physician?

Date of Last Physical Examination?

Have you ever been hospitalized?

- ○ Yes
- ○ No

If yes, please explain.

What medications are you currently taking?- including over the counter, vitamins, supplements and oral contraceptives.

Are you allergic to any of the following:

- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Metal
- ☐ Penicillin
- ☐ Sulfa

Other known allergies including food allergies

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Do you now have or have you ever had any of the following?

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Adhesive allergy
- [ ] Alcoholism
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy-Amoxcillin
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Aspirin Therapy
- [ ] Asthma
- [ ] Autoimmune Disorder
- [ ] Bisphosphonates hx
- [ ] Bleeding Disorder
- [ ] Cancer
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fainting
- [ ] GERD/Acid Reflux
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Metal Allergy
- [ ] Nervous/Anxiety
- [ ] No Epi
- [ ] Oral Infection
- [ ] Osteoporosis
- [ ] Other_______
- [ ] Pacemaker
- [ ] Plavix/Coumadin
- [ ] Pregnancy
- [ ] Radiation/Chemo
- [ ] Recreation Drugs
- [ ] Red Dye Allergy
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Sleep Apnea
- [ ] Smoking/Tobacco
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] Tumors / Growths
- [ ] Vertigo/Dizziness

WOMEN: Is there a possibility that you are pregnant?

○ Yes ○ No

Additional Notes:

To the best of my knowledge, all preceding answers are correct. If I have any changes in my health status, I shall inform the dentist and/or the staff at the next dental appointment.

Signature: ______________________________ Date: __________