Corey J. Porche, DDS

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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.

☐ Allergies/hayfever	☐ Allergy - Aspirin	☐ Allergy - Iodine	☐ Allergy - Latex
☐ Allergy - Metal	☐ Allergy - Sulfa	☐ Allergy -Antibiotic	☐ Allergy -Epinephrine
☐ Anemia	☐ Angina	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Cancer	☐ Chest Pains	☐ Cholesterol
☐ Diabetes	☐ Dialysis	☐ Easily Winded	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Fainting	☐ Frequently Tired	☐ Glaucoma
☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ HIV or AIDS	☐ Kidney Disease	☐ Liver Disease
☐ Low BP	☐ MVP and/or regurge	☐ Pacemaker	☐ Radiation/Chemo
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Stomach Problems	☐ Stroke
☐ Thyroid	☐ Tobacco user	☐ Tuberculosis	☐ Valve Replacement

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:

_____

_____

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:

☐ * **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: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Response Date: _____