Torrance Dental Care

www.TorranceDentalCare.net office@torrancedentalcare.net

3949 Artesia Blvd • Torrance, CA 90504 (310)878-0880

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 - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Allergies
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Blood Thinners	☐ Cancer	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Glaucoma	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Hep - A	☐ Hep - B	☐ Hep - C	☐ High Blood Pressure
☐ HIV	☐ Jaundice	☐ Kidney Disease	☐ Liver Disease
☐ Mental Disorders	☐ Nervous Disorders	☐ Other	☐ Pacemaker
☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Thyroid Condition	☐ Tuberculosis	☐ Tumors	☐ Ulcers
☐ Venereal Disease			

☐ Ever been hospitalized (illness or injury)	☐ Presently being treated for any other illnesses	☐ Subject to frequent headaches
☐ Tobacco/Alcohol Use	☐ FEMALE: Taking birth control pills	☐ FEMALE: Pregnant

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 phone number:

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

List all medications (prescription and non-prescription) including regular doses of aspirin:

☐ ***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.**

Response Date: ___________