GRANDVIEW DENTAL
ADAM MCLACHLAN DDS

Medical History

Patient Name _____ DOB _____

1. Are you currently under a physician's care (for reasons other than routine/preventative care)
   ☐ Yes ☐ No If yes, please explain _____
   Physician's name _____ Phone _____
2. Have you had any serious illnesses or operations?
   ☐ Yes ☐ No If yes, please explain _____
   _____
3. Have you been in an accident resulting in a head or neck injury?
   ☐ Yes ☐ No If yes, please explain _____
   _____
4. **WOMEN:**
   Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No
5. Do you require any antibiotic premedication for your dental appointments?
   ☐ Yes ☐ No If yes, please select from the list below.
   ☐ Amoxicillin ☐ Clindamycin ☐ Other
6. Do you take any anti-clotting medication such a Coumadin, Warfarin or Aspirin?
   ☐ Yes ☐ No

Check if you have or had have any of the following:

- ☐ Acid reflux
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Cancer, type _____
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Diabetes, type _____ A1C _____
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart problems/chest pain
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV or AIDS
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric treatment
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Sexually transmitted disease
- ☐ Stroke
- ☐ Swelling of feet and ankles
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other _____

List any medications (RX and OTC), supplements and allergies below:

Medications and supplements	**Allergies**

Signature _____ Date _____
(Responsible party if under 18 years old)