Mabry & Mabry Dentistry LLC

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Medical History

Please take a moment to update our office on your medical history to help us ensure the quality of your care is excellent.

Name of Family Doctor/ Phone #:

_____

_____

Date of last Medical Exam: _____

Are you under a physician's care now? (If Yes, please explain.)

_____

_____

Please indicate if you have ever experienced any of the following: (Checkmark = YES)

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ *Pre-Med - Valium
☐ Allergy - Codeine	☐ Allergy - Latex	☐ Allergy - OTHER	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Alzheimers/Dementia	☐ Anemia	☐ Anticoagulant Therap
☐ Arthritis	☐ Artificial Joints	☐ Asthma	☐ Autism
☐ Autoimmune Disease	☐ Bleeding Disorder	☐ Cancer	☐ Cerebral Palsy
☐ Chem Depen/Recovery	☐ Cold Sores / Herpes	☐ Currently Pregnant	☐ Diabetes
☐ Dizziness	☐ Epilepsy/seizures	☐ Epinephrine	☐ GERD
☐ Glaucoma	☐ Head Injuries	☐ Hearing Disorder/Aid	☐ Heart Attack
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ HIV Positive	☐ Intestinal Issues	☐ Kidney Disease	☐ Liver Disease
☐ Mental Disorders	☐ OTHER	☐ Pacemaker	☐ Recent Surgeries
☐ Respiratory Problems	☐ Sinus Problems	☐ Sleep Apnea	☐ Special Needs
☐ Stroke	☐ Taking Medications	☐ Thyroid problems	☐ Tobacco use
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Wheelchair Use

Details from previous page (Hep status, Cancer, etc.)

_____

_____

_____

_____

_____

_____

_____

Allergies Other

Current Medications:

List of Medications currently taking:

☐ *I confirm the above is accurate and correct.

Response Date: ____/____/_____