Jody W. Ames DDS, LLC

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Medical History Form

Patient Information

Name
Gender
DOB
Phone

Conditions						
*PRE MED	Yes	☐	No	☐	Don't Know	☐
Acid reflux	Yes	☐	No	☐	Don't Know	☐
AutoImmune Disease	Yes	☐	No	☐	Don't Know	☐
Blood Disease	Yes	☐	No	☐	Don't Know	☐
Cancer	Yes	☐	No	☐	Don't Know	☐
Chemotherapy	Yes	☐	No	☐	Don't Know	☐
Chest pain	Yes	☐	No	☐	Don't Know	☐
COPD	Yes	☐	No	☐	Don't Know	☐
Diabetes	Yes	☐	No	☐	Don't Know	☐
Dizziness	Yes	☐	No	☐	Don't Know	☐
Epilepsy	Yes	☐	No	☐	Don't Know	☐
Fainting	Yes	☐	No	☐	Don't Know	☐
Frequent headaches	Yes	☐	No	☐	Don't Know	☐
Glaucoma	Yes	☐	No	☐	Don't Know	☐

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).	Yes	☐	No	☐	Don't Know	☐
Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.	Yes	☐	No	☐	Don't Know	☐
Head Injuries	Yes	☐	No	☐	Don't Know	☐
Heart Disease	Yes	☐	No	☐	Don't Know	☐
Heart Murmur	Yes	☐	No	☐	Don't Know	☐
Heart Surgery	Yes	☐	No	☐	Don't Know	☐
Heart Trouble	Yes	☐	No	☐	Don't Know	☐
Hepatitis	Yes	☐	No	☐	Don't Know	☐
High/Low Blood Press	Yes	☐	No	☐	Don't Know	☐
HIV	Yes	☐	No	☐	Don't Know	☐
Hives/skin rash	Yes	☐	No	☐	Don't Know	☐
Hysterectomy	Yes	☐	No	☐	Don't Know	☐
Jaundice	Yes	☐	No	☐	Don't Know	☐
Joint Replacement	Yes	☐	No	☐	Don't Know	☐
Kidney Disease	Yes	☐	No	☐	Don't Know	☐
Liver Disease	Yes	☐	No	☐	Don't Know	☐
Lung/Breathing	Yes	☐	No	☐	Don't Know	☐
Medical Marijuana	Yes	☐	No	☐	Don't Know	☐
Mental Disorders	Yes	☐	No	☐	Don't Know	☐
Mitral valve prolaps	Yes	☐	No	☐	Don't Know	☐

Nervous Disorders	Yes	☐	No	☐	Don't Know	☐
Nervousness	Yes	☐	No	☐	Don't Know	☐
Pacemaker	Yes	☐	No	☐	Don't Know	☐
Persistent Cough	Yes	☐	No	☐	Don't Know	☐
Radiation Treatment	Yes	☐	No	☐	Don't Know	☐
Recreational Marijuana	Yes	☐	No	☐	Don't Know	☐
Respiratory Problems	Yes	☐	No	☐	Don't Know	☐
Rheumatic Fever	Yes	☐	No	☐	Don't Know	☐
Rheumatism	Yes	☐	No	☐	Don't Know	☐
Shortness of Breath	Yes	☐	No	☐	Don't Know	☐
Sinus Problems	Yes	☐	No	☐	Don't Know	☐
Smokeless Tobacco (Vape)	Yes	☐	No	☐	Don't Know	☐
Stomach Problems	Yes	☐	No	☐	Don't Know	☐
Stroke	Yes	☐	No	☐	Don't Know	☐
Swelling feet,hands	Yes	☐	No	☐	Don't Know	☐
Tobacco	Yes	☐	No	☐	Don't Know	☐
Tuberculosis	Yes	☐	No	☐	Don't Know	☐
Other Conditions						

Allergies						
Amoxicillin	Yes	☐	No	☐	Don't Know	☐
Antihistamine	Yes	☐	No	☐	Don't Know	☐

Aspirin	Yes	☐	No	☐	Don't Know	☐
Augmentin	Yes	☐	No	☐	Don't Know	☐
Codeine	Yes	☐	No	☐	Don't Know	☐
Hydrogen Peroxide ri	Yes	☐	No	☐	Don't Know	☐
Latex	Yes	☐	No	☐	Don't Know	☐
MINT	Yes	☐	No	☐	Don't Know	☐
Penicillin	Yes	☐	No	☐	Don't Know	☐
Shell Fish	Yes	☐	No	☐	Don't Know	☐
Sulfa Drugs	Yes	☐	No	☐	Don't Know	☐
Other Allergies						

Medical Questionnaire

Physician's Name:

Date of last visit?

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name:

Phone #:

Dental Questionnaire

Patient Information:

Address:

E-mail:

Sex:

Birthdate:

Marital Status:

Employer/School Phone:

Patient Employer/School:

Occupation:

Employer/School Address:

Spouse's Name:

Spouse's Birthdate:

SS #:

Spouse's Employer:

Dental History:

Reason for today's visit:

Former Dentist:

Address:

Date of last dental X-rays:

Date of last dental visit:

Date of last dental visit:

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath

○ Yes ○ No

Bleeding gums

○ Yes ○ No

Blisters on lips or mouth

○ Yes ○ No

Blisters on lips or mouth

○ Yes ○ No

By signing below, I certify that all the above information is true to the best of my knowledge. I understand the importance of this information and that the practice will rely on this information for treating me. I will not hold the practice or any member / staff of the practice, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party

Signed on