Michael Schuiling DDS PLLC

www.blackberrydental.com info@blackberrydental.com
P.O. Box 8031 | 708 N. Main St • Elburn, IL 60119 (630)365-6127

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

What is your estimate of your general health?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Name of primary care physician and phone number:

_____

_____

Name of physician specialist and phone number (cardiologist, orthopedic surgeon, oncologist, etc):

_____

_____

Are you currently pregnant? ◯ Yes ◯ No

Are you currently nursing? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Have you ever had any of the following? Please check all that apply:

- ☐ AIDS/HIV Positive
- ☐ Allergy Amoxicillin
- ☐ Allergy Codeine
- ☐ Allergy Erythromycin
- ☐ Allergy Latex
- ☐ Allergy Penicillin
- ☐ Allergy Sulfa
- ☐ Allergy Tetracycline
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bisphosphonate History
- ☐ Blood Thinner
- ☐ Brain Bleed
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold sores
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Gastrointestinal
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Headaches
- ☐ Heart Attack/Failure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Renal Dialysis
- ☐ Require Dental Premed
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sensitivity to Epinepherine
- ☐ Sinus Problems
- ☐ Smoker
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

If you have any other conditions, or any conditions selected above need further clarification, please describe below:

_____

_____

Please list any environmental, food or medicinal allergies you may have:

Describe any current medical treatment or impending surgeries.

Please list any surgeries and the date they took place.

Are you taking any prescription or non-prescription medication? If yes, please list below. ◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

Do you require antibiotic premedication for your dental visits? If yes, please explain why.

Response Date: _____