Dr. Philip M. Robitaille
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1188 County Street • Somerset, MA 02726 (508)674-0551

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

Medical History

Indicate which of the following conditions you have or had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Abnormal Bleeding
- ☐ Angina
- ☐ Artificial (prosthetic) Heart Valves
- ☐ Blood Transfusion
- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ Emphysema
- ☐ Gastrointestinal Disease
- ☐ Hepatitis, Jaundice, Liver Disease
- ☐ Kidney Problems
- ☐ Pacemaker
- ☐ Seizures
- ☐ Systemic Lupus Erythematosus
- ☐ Ulcers
- ☐ AIDS or HIV Infection
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest pain upon exertion
- ☐ Damaged Heart Valves
- ☐ Epilepsy
- ☐ Heart Attack, date _____
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Persistent Swollen Glands
- ☐ Sexually Transmitted Disease
- ☐ Thyroid Problems
- ☐ Anemia
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Cancer / Chemo / Radiation
- ☐ Congenital Heart Disease (CHD)
- ☐ Diabetes type I or II
- ☐ Fainting Spells
- ☐ Hemophilia
- ☐ Infective Endocarditis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Stroke, Date _____
- ☐ Tuberculosis

Any other conditions / problems you think we should be aware of:

_____

_____

Are you allergic to or have had a reaction to:

- ☐ Animals
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Latex (rubber)
- ☐ Penicillin or other antibiotics _____
- ☐ Other _____
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Local anesthetics
- ☐ Sulfa drugs

Physician Name, Address and Number

_____

_____

1) Has a physician or previous dentist recommended that you take antibiotics prior to your dental appointment? If so, for what?

_____

2) Have you ever had a an orthopedic joint (hip,knee,elbow,finger) replacement? If so, what date? _____

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

_____

_____

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

_____

_____

☐ * **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 allergies that I have not listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Signature _____ **Date** _____

Response Date: ____/____/_____