Broadway Heights Dental

broadwayheightsdental.com | office@broadwayheightsdental.com

12120 E Broadway Ave - Spokane, WA 99206 | (509) 926-8866

Patient Name: ______________________ , ______ , ______________________ , ______________________
First | MI | Last | Preferred Name

Medical History

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

- ☐ Joint Replacement
- ☐ Premed
- ☐ Allergy – Penicillin
- ☐ Allergy – Clindamycin
- ☐ Allergy – Doxycycline/Minocycline
- ☐ Allergy – Aspirin/Ibuprofen
- ☐ Allergy/Adverse Reaction – Anesthetic
- ☐ Allergy – Other
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Chemo
- ☐ Radiation
- ☐ FEMALE: Currently Pregnant
- ☐ FEMALE: Currently Nursing
- ☐ ☐ Diabetes
- ☐ ☐ Neurological/Developmental Condition
- ☐ ☐ Seizures/Epilepsy
- ☐ ☐ Dizziness/Fainting
- ☐ ☐ Alzheimer's
- ☐ ☐ Autoimmune Disease
- ☐ ☐ Stroke
- ☐ ☐ Thyroid Disease
- ☐ ☐ Kidney Disease
- ☐ ☐ Liver Disease
- ☐ ☐ Cold Sores
- ☐ ☐ Sleep Apnea
- ☐ ☐ Snoring
- ☐ ☐ Tobacco/Nicotine Use

1. If any conditions or alerts selected above need further explanation, please describe below:

____

____

____

2. Please list any medications (prescription and non-prescription):

____

____

____

3. If you selected "Joint Replacement" above, have you been advised by your surgeon/physician to take an antibiotic/Premed prior to dental appointments? If so, please state the antibiotic recommended:

____

4. If you selected "Osteoporosis" above, which medications (if any) have you taken? (Fosamax,Boniva,Prolia,etc)

____

5. Please list any hospitalizations or surgeries in the past 3 years:

____

____

____

6. Have you ever been told you have gum disease or have had a deep cleaning requiring anesthetic? YES____NO_____

7. Please provide the name of your physician and phone number:

____

8. Please provide the name, location, and phone number of your preferred pharmacy:

____

Patient Signature: (or parent/guardian if minor) ________________________________ Date: ____________