Allure Dental

Alluredental.com
821 Twyckenham Blvd. • Lafayette, IN 47909
info@alluredental.com
(765)477-0331

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

Medical History

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

- ☐ *Allergy - Latex
- ☐ Anemia
- ☐ Autism
- ☐ Breastfeeding
- ☐ Chemo--PRESENT
- ☐ Fainting
- ☐ Headaches
- ☐ Hepatitis
- ☐ Mental disorders
- ☐ Other--list below
- ☐ Radiation--PAST
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Venereal Disease
- ☐ *Pre-Med needed
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ COPD
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Mirtral valve prolapse
- ☐ PREGNANT
- ☐ Radiation--PRESENT
- ☐ Sinus Problems
- ☐ Tuberculosis (TB)
- ☐ Allergies--list below
- ☐ Artificial Joints
- ☐ Blood disease
- ☐ Cancer
- ☐ Dizziness
- ☐ HIV
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Nervous disorders
- ☐ Pacemaker
- ☐ Respiratory problems
- ☐ Sleep apnea
- ☐ Tumors
- ☐ Alzheimer's disease
- ☐ Asthma
- ☐ Blood thinners
- ☐ Chemo--PAST
- ☐ Epilepsy
- ☐ Head injuries
- ☐ Heart problems
- ☐ Liver disease
- ☐ Organ transplant
- ☐ Parkinson's Disease
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Ulcers

- ☐ Alcohol Use
- ☐ Vape
- ☐ Smoke
- ☐ Presently being treated for any other illnesses
- ☐ Chew
- ☐ Ever been hospitalized (illness or injury)

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

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

_____

_____

Name of your Physician and phone number:

_____

_____

Name of your Cardiologist, phone & fax number:

_____

_____

Name of your Orthopedic, phone & fax number:

_____

_____

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

_____

_____

PROVIDE A LIST OF MEDICATIONS: ◯ Yes ◯ No

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

_____

_____

_____

_____

_____

Do you have any medication allergies? If yes, please list.

_____

_____

Signature _____ **Date** _____

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

Response Date: _____