900 Sixth St N Ste 200
Hudson, WI 54016

(715)386-5888
info@bardilldental.com

Bardill Dental Associates, S.C.

Patient Information

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.

☐ AIDS/HIV	☐ Allergies	☐ Anemia
☐ Angina	☐ Arteriosclerosis	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Autoimmune Disease
☐ Bisphosphonates	☐ Blood Disorder	☐ Blood Transfusion
☐ Cancer	☐ Chemical Dependency	☐ Chemotherapy
☐ Chronic Bronchitis	☐ Congential Heart	☐ Congestive Heart
☐ Coronary Artery Dis	☐ Damaged Heart Valves	☐ Diabetes
☐ Eating Disorder	☐ Emphysema	☐ Epilepsy
☐ Fainting or Seizures	☐ Gastrointestinal Dis	☐ Glaucoma
☐ Headaches/Migraines	☐ Hearing Loss	☐ Heart Attack
☐ Heart Murmur	☐ HeartValve Replace	☐ Hemophilia
☐ Hepatitis	☐ High/Low BP	☐ Kidney Disease
☐ Latex Allergy	☐ Meds Allergy	☐ Mental Health Issues
☐ MitralValve Prolapse	☐ Myasthenia Gravis	☐ NeurologicalDisorder
☐ Osteoporosis	☐ Pacemaker	☐ Penicillin Allergy
☐ Pregnancy	☐ Pre-Med	☐ Radiation
☐ RheumaticHeart/Fever	☐ Rheumatoid Arthritis	☐ Sinus Trouble
☐ Sleep Disorders	☐ STD	☐ Stroke
☐ Systemic Lupus	☐ Thyroid Disorders	☐ Tobacco Use

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- [ ] Tuberculosis

- [ ] Ever been hospitalized (illness or injury)
- [ ] Taking medication for weight control (ie fen-phen)
- [ ] Subject to frequent headaches
- [ ] Presently being treated for any other illnesses
- [ ] Taking dietary supplements
- [ ] A smoker or smoked previously

FEMALES ONLY:

- [ ] Taking contraceptives
- [ ] Pregnant or planning pregnancy
- [ ] Using Hormone Replacement Therapy
- [ ] Nursing

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.

What is your estimate of your general health?

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

Name of your physician and your most recent physical exam:

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

Have you had an orthopedic total joint replacement (hip,knee,elbow,finger), if so, please describe below. Please include any complications from procedure: