Are you allergic to or have you had a reaction to:

Patient Name:____

- ○ **Amoxicillin**
- ○ **Erythromycin**
- ○ **Penicillin**
- ○ **Sulfa Drugs**
- ○ **Tetracycline**
- ○ **Codeine or other narcotics**
- ○ **Aspirin**
- ○ **Latex**
- ○ **Dental anesthetics**
- ○ **Other**

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MEDICATIONS:

Prescription & non-prescription medicines, vitamins, Birth control pills, Home remedies herbs:

Medication	Taken for

Medication	Taken for

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

X

- Signed
- Date

Staff Medical History Review (for internal use only)

1. **BP**_________________________ **P**________________
   Changes
   ____
   ____
   Initial______________________ **Date**______________

2. **BP**_________________________ **P**________________
   Changes
   ____
   ____
   Initial______________________ **Date**_____________

3. **BP**_________________________ **P**________________
   Changes
   ____
   ____
   Initial______________________ **Date**______________

4. **BP**_________________________ **P**________________
   Changes
   ____
   ____
   Initial______________________ **Date**______________

5. **BP**_________________________ **P**________________
   Changes
   ____
   ____
   Initial______________________ **Date**______________

6. **BP**_________________________ **P**________________
   Changes
   ____
   ____
   Initial______________________ **Date**______________