

Maple Street Clinic
 109 E. Maple
 Gillespie, IL 62033
 217-839-1526 – Medical/Behavioral
 217-839-4110 – Dental



Morgan Street Clinic
 1115 Morgan Street
 Carlinville, IL 62626
 217-854-3692 – Medical/Behavioral
 217-854-6823 – Dental

MAPLE/MORGAN STREET DENTAL CLINIC/MACOUPIN COUNTY PUBLIC HEALTH CLINIC SITE

Last Name: _____ First Name: _____ MI: _____ Today's Date: _____

Birth Date: _____ Sex: M / F / FTM / MTF

If the patient is a minor, please provide the parent's/guardian's name: _____

MEDICAL HISTORY

Do you have a medical doctor? YES NO

Medical doctor's name: _____ Phone Number: _____

Please list all the medication you are currently taking including dose and directions:

Have you ever taken or are you currently taking Bisphosphonate drug such as Zometa, Fosamax, Actonel, Boniva, or Aredia?

Y N If yes, which drug(s)? _____

Y	N	High Blood Pressure	Y	N	Herpes/Fever Blisters	Y	N	Epilepsy/Seizures
Y	N	Low Blood Pressure	Y	N	HIV+/AIDS	Y	N	Migraines/Headaches
Y	N	Pacemaker	Y	N	Hepatitis	Y	N	Fainting/Dizzy spells
Y	N	Mitral Valve Prolapse	Y	N	Liver Disease	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Kidney Problems	Y	N	Psychiatric Conditions
Y	N	Heart Surgery	Y	N	Diabetes	Y	N	Difficulty Breathing
Y	N	Heart Murmur	Y	N	Ulcers/Colitis	Y	N	Coronary Artery Disease
Y	N	Congenital Heart Defect	Y	N	Arthritis	Y	N	Asthma
Y	N	Anemia	Y	N	Artificial Joints/Valves	Y	N	Emphysema
Y	N	Bleeding Problems	Y	N	Cancer	Y	N	Stroke
Y	N	Bruise Easily	Y	N	Chemotherapy	Other Conditions not listed:		
Y	N	Sickle Cell Anemia	Y	N	Radiation Treatment	_____		
Y	N	Hemophilia	Y	N	Hospitalized for any reason	_____		

Y N **Tobacco use?** If yes, how many packs a day? _____ How many years? _____

Y N **Alcohol use?** If yes, how many drinks per week? _____

Y N **Drug abuse?** If yes, what drugs? _____

FOR WOMEN

Y N Are you pregnant? If yes, when is your due date? _____

Y N Are you nursing?

ALLERGIES

Are you allergic to any of the following:

Y	N	Dental Anesthetic	Y	N	Penicillin	Y	N	Codeine
Y	N	Aspirin	Y	N	Amoxicillin	Y	N	Erythromycin
Y	N	Latex	Y	N	Metals			

Other: _____

DENTAL HISTORY

When was your last dental exam? _____

What is the reason for your visit today? _____

If you have dentures when/where were they placed? _____

PATIENT AUTHORIZATION/CONSENT TO TREATMENT

The information I have provided is correct to the best of my knowledge. I assume any risk to myself or my dependent and understand that I will ask if there are any questions regarding diagnosis or treatment. I understand it is my responsibility to inform this office of any changes in my/my dependent's medical status and/or medications being taken. I authorize treatment, the use of nitrous oxide, anesthesia, oral sedation and/or other medications necessary to be rendered by the staff. I understand that I will be expected to update the information on this history form on an annual basis.

Patient/Parent's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

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