Dr. Regan Ackerman, DMD
Freedom Mini Dental Implants
4906 Bardstown Road
Louisville, KY 40291

MEDICAL HISTORY FORM

FREEDOM MINI DENTAL IMPLANTS

Patient Name: _____ Birthdate ___/___/_____ SS# _____

Address: _____ City: _____ State: ____ Zip: _____

Phone – Home: _____ Cell: _____ Work: _____

Emergency contact name and phone #: _____

How did you hear about us? _____

MEDICAL HISTORY QUESTIONNAIRE

1. Please check "Yes" or "No":

- Are you under physician's care now? ☐ Yes or ☐ No If yes, please explain _____
- Have you ever had a reaction to epinephrine or any dental anesthetic used to get you numb ? ☐ Yes or ☐ No
  If yes, please explain _____
- Have you ever had a serious head or neck injury or head/neck RADIATION ? ☐ Yes or ☐ No
  If yes, please explain _____
- Are you currently taking a blood thinner ? ☐ Yes or ☐ No
- Please list prescription medications and over the counter medications and purpose, e.g. *blood pressure pill:*

_____

_____

_____

2. Women patients:

- Are you pregnant or trying to get pregnant ? ☐ Yes or ☐ No Nursing ? ☐ Yes or ☐ No
- Are you taking oral contraception ? ☐ Yes or ☐ No

3. Are you allergic to any of the following?: ☐ Yes or ☐ No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa ☐ Other _____

4. Do you have or have you had any of the following? (check the box next to the condition):

☐ AIDS/HIV Positive	☐ Diabetes	☐ Hepatitis	☐ Psychiatric Care
☐ Anaphylaxis	☐ Drug Addiction	☐ High Blood Pressure	☐ Radiation Treatments
☐ Arthritis / Gout	☐ Epilepsy / Seizures	☐ High Cholesterol	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Kidney Problems	☐ Stomach / Intestinal Disease
☐ Asthma	☐ Fainting Spells / Dizziness	☐ Liver Disease	☐ Stroke
☐ Blood Disease	☐ Frequent Cough	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Heart Attack / Failure	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chest Pains	☐ Heart Pacemaker	☐ Osteoporosis	☐ Replaced / Artificial Joint
☐ Congenital Heart Disorder	☐ Heart Trouble / Disease	☐ Pain in Jaw Joints	What?_____ Year? _____ What?_____ Year? _____ What?_____ Year? _____

5. Have you ever had any serious illness not listed above? ☐ Yes or ☐ No

If yes, explain: _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ **DATE** _____