Joseph A Craddock DDS PLLC
Medical/COVID-19 Health Form

Patient Name: ______________________ **Birth Date:** ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may take, could have an important interrelationship with the dentistry you receive.

Please complete the following:

Name of physician and specialists you see:

Have you ever been hospitalized or had any major operation(s)? If yes, what and when:

Please list ALL medications you take, including over the counter & herbal meds:

Have you ever taken Fosamax, Boniva, Actonel or any other medications w/biophosphonates?

Do you use tobacco? If yes, what type and how much/often?

Do you use controlled substances? If yes, name of drug?

Women: Are you.....

- **Pregnant/Trying to get Pregnant?** ☐
- **Taking oral contraceptives?** ☐
- **Nursing?** ☐

Are you allergic to any of the following?

☐ **Aspirin**	☐ **Penicillin**	☐ **Codeine**	☐ **Acrylic**
☐ **Metal**	☐ **Latex**	☐ **Sulfa Drugs**	☐ **Local Anesthetics**

Any other allergies? If yes, what?

COVID-19/CORONAVIRUS

Question	Yes	No
Do you have or have you felt hot or feverish in the last 14-21 days?	☐	☐
Are you having shortness of breath or other difficulties breathing?	☐	☐
Do you have a cough?	☐	☐
Any flu like symptoms- upset stomach, headache, fatigue?	☐	☐
Have you experienced recent loss of taste or smell?	☐	☐
Have you been in direct contact with any confirmed COVID-19 positive patients?	☐	☐

Current Health:

Condition		Condition		Condition	
Aids/HIV Postitive		Epilepsy or Seizures		Low Blood Pressure	
Alzheimers Disease		Excessive Bleeding		Lung Disease	
Anaphylaxis		Fainting Spells/Dizziness		Osteoporosis	
Anemia		Frequent Cough		Pain in Jaw Joints	
Angina/Chest Pain		Frequent Diarrhea		Psychiatric Care	
Arthritis/Gout		Frequent Headaches		Radiation Treatments	
Artificial Heart Valve		Glaucoma		Recent Weight Loss	
Artificial Joint		Hay Fever		Renal Dialysis	
Asthma		Heart Attack/Failure		Rheumatism	
Blood Disease		Heart Pacemaker		Shingles	
Breathing Problems		Heart Trouble/Disease		Sinus Trouble	
Bruise Easily		Hepatitis A, B or C		Sleep Apnea	
Cancer		Herpes		Stomach/Intestinal Disease	
Chemotherapy		High Blood Pressure		Stroke	
Cold Sores/Fever Blisters		High Cholesterol		Swelling of Limbs	
Congenital Heart Disease		Hives or Rash		Thyroid Disease	
Cortisone Medicine		Irregular Heartbeat		Tonsilitis	
COVID-19/Coronovirus		Kidney Problems		Tuberculosis	
Diabetes		Leukemia		Tumors/Growths	
Easily Winded		Liver Disease		Ulcers	
Emphysema					

Have you ever had any serious illness, not listed above? Yes ☐ No ☐

If yes:

Is there any other information we should know that may affect your dental care or dental concerns you may have?

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 health. It's my responsibility to inform the dental office of any changes in my medical status.

Patient (or guardian) signature *Date*