Rene' A. Talbot, D.D.S.
www.yourhuntsvilledentist.com
info.yourhuntsvilledentist@gmail.com
4000 Balmoral Drive, Suite 202 • Huntsville, AL 35801 (256)881-8181

Medical History

Patient Name: _____ (Last) _____ (First) _____ (MI)

_____ (Preferred Name)

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.

- ☐ *Pre-Med
- ☐ Allergy-Anesthetics
- ☐ Allergy-Codeine
- ☐ Allergy-Hydrocodone
- ☐ Allergy-Latex
- ☐ Allergy-Penicillin
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Gum Treatment
- ☐ Hay Fever/Sinus
- ☐ Head Injuries
- ☐ Heart Condition
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ MVP
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism/Arthritis
- ☐ Sinus Problems
- ☐ STD / HPV
- ☐ Stomach Problems
- ☐ Stroke
- ☐ TMJ Disorder
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ xOther-Explain Below

- ☐ Subject to frequent headaches
- ☐ Tobacco/Alcohol Use
- ☐ FEMALE: Pregnant or Planning Pregnancy
- ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification, please describe below (including due date if pregnant):

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have ever had Botox or Juvederm proceedures in the past? Would you be interested in these proceedures in the future? * ○ Yes ○ No

If you have had Botox or Juvederm in the past, did you experience any adverse reaction? * ○ Yes ○ No

Do you take antibiotic premedication for your dental visits? If yes, please explain below. * ○ Yes ○ No

Pre-Med:

Are you taking any medications (prescription and non-prescription) including regular doses of aspirin or birth control pills? If yes, please list below. * ◯ Yes ◯ No

Medications:

Do you have any allergies (including allergies to medications)? If yes, please explain below * ◯ Yes ◯ No

Allergies:

Name of your Physician and phone number:

Name and phone number of preferred Pharmacy:

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

Signature

Date