Jacob Robichaux, DDS

RobichauxFamilyDental.com

235 Corporate Drive • Houma, LA 70360 (985)580-3200

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.

☐ Allergies	☐ Alzheimer's Disease	☐ Amoxicillion	☐ Anaphalaxis
☐ Anemia	☐ Angina	☐ Anxiety	☐ Arthritis
☐ Artificial Joints	☐ Aspergers syndrome	☐ Asprin	☐ Asthma
☐ Augmentin	☐ Autism	☐ Blood Disease	☐ Bradycardia
☐ Brilinta	☐ Cancer	☐ Cephelexin	☐ Chemo and Radiation
☐ Cipro	☐ Codeine Allergy	☐ Crestor	☐ Depression
☐ Diabetes	☐ Dizziness	☐ Drug addiction	☐ Emphysema
☐ Epilepsy	☐ Epinephrine	☐ Excessive Bleeding	☐ Fainting
☐ Familial hypercholes	☐ Fibromialgia	☐ Frequent Cough	☐ Frequent headaches
☐ Glaucoma	☐ Gout	☐ Growths	☐ HIV
☐ Hay Fever	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Hemophilia	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ Hives/Rash	☐ Hydrocodone	☐ Hypoglycemia	☐ Jaundice
☐ Joint replacement	☐ Kidney Disease	☐ Knee replacement	☐ Latex
☐ Lipitor	☐ Lisinopril	☐ Livalo	☐ Liver Disease
☐ Lortab	☐ Low Blood Pressure	☐ MVP	☐ Macrobid
☐ Mental Disorders	☐ Morphine	☐ Nervous Disorders	☐ Osteoporosis
☐ Other	☐ PTSD	☐ Pacemaker	☐ Pain in Jaw joints
☐ Paraspinous mass	☐ Penicillin	☐ Penicillin Allergy	☐ Praluent Pen
☐ Pregnancy	☐ Premed patient	☐ Primary hypertension	☐ Psychiatric Care
☐ Radiation Treatment	☐ Reflux	☐ Renal Dialysis	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ SVT	☐ Schizophrenia
☐ Seborrheic Dermatiti	☐ Shingles	☐ Singulair	☐ Sinus Problems
☐ Stomach Problems	☐ Stroke	☐ Sudafed	☐ Sulfa
☐ Swelling of Limbs	☐ Thyroid Disease	☐ Tonsillitis	☐ Trilipix
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease
☐ Vytorin	☐ Zetia	☐ calcium	☐ codine
☐ pulmonary hypertensi	☐ tramadol		

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

____

____

____

____

Allergies not listed:

____

____

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

Pre-Med:

____

____

Name of your Physician and Phone Number:

____

____

Preferred Pharmacy and Phone Number:

____

____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

____

____

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

____

____

____

____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ ____________________ ____ ____________________
Last First MI Preferred Name

Title: __________ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: __________ **Prev. Visit:** __________ **Email Address:** ____________________

Phone: __________ __________ __________ ______ **Best time to call:** ____________________
Home Mobile Work Ext

Address: ____________________ ____________________
Address 1 Address 2

____________________ ______ _____-____
City State Zip Code

Response Date: __________