Robert D. Arnold, D.M.D.

MEDICAL INFORMATION FORM

Date: _____

Patient's Name: _____
LAST FIRST MIDDLE

Mobile Telephone Number: ( ) -

Email Address: _____

Birthdate: __/__/__
MONTH DAY YEAR

MEDICAL PROVIDER INFORMATION

Primary Physician's Name: _____

Physician's Telephone Number: ( ) -

Medical Specialist's Name: _____ Specialty: _____

Specialist's Telephone Number: ( ) -

MEDICATIONS

Please list all medications that you are currently taking (or attach a list): _____

Please list any allergies: _____

Please list any type of illegal drug use: _____

Please list any type of herbs or natural supplements use: _____

Have you ever taken Fosamax, Zometa, Boniva or another drug of the same class? ☐ Yes ☐ No

Are you currently taking any type of blood thinner? ☐ Yes ☐ No

Have you ever had any type of adverse reaction to any type of anesthetic? _____
If yes, what occurred?: _____

List any previous surgeries and the dates: _____

CURRENT INFORMATION

Pregnant	☐ Yes	☐ No		
Sinus Issues	☐ Yes	☐ No		
Illnesses	☐ Yes	☐ No	If yes, please list:	_____
Under Medical Care	☐ Yes	☐ No	If yes, please list:	_____

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HEALTH ISSUES

Prosthetic Joints	☐ Yes	☐ No	Procedure and date: _____
Pins, Screws, Rods, Metal Remaining after Surgery	☐ Yes	☐ No	If yes, please list: _____
Cardiac Stents	☐ Yes	☐ No	Procedure and date: _____
Pacemaker	☐ Yes	☐ No	Type and date: _____
Please List any Cardiac Valve Issues:			_____
Spinal Fusion	☐ Yes	☐ No	Procedure and date: _____
Seizure Disorder	☐ Yes	☐ No	Date of last seizure: _____
History of Fainting	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	Date of stroke: _____
Chemotherapy/Radiation	☐ Yes	☐ No	Date Completed: _____
Gastric Bypass	☐ Yes	☐ No	Procedure date: _____
Liver Disease	☐ Yes	☐ No	
HIV Positive or Aids	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	
Lymphatic/Immune System	☐ Yes	☐ No	If yes, please list: _____
Respiratory Problem	☐ Yes	☐ No	If yes, please list: _____
Asthma	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Anxiety Disorder	☐ Yes	☐ No	
Autism	☐ Yes	☐ No	
Dementia	☐ Yes	☐ No	
Bleeding Disorder	☐ Yes	☐ No	

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Signature: _____ Date: _____