Bryan Stephens, D.D.S., Inc

https://www.bryanstephensdds.com/ drbms@sbcglobal.net
60 N. Miller Rd. • Akron, OH 44333 (330)867-7741

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.

☐ **Premed	☐ *Allergy: Latex	☐ Allergy: Penicillin	☐ Alzheimer's/Dementia
☐ Anemia	☐ Arthritis/Rheumatism	☐ Artificial Joints	☐ ArtificialHeartValve
☐ Asthma	☐ Blood Disease	☐ Blood Transfusion	☐ Bruise Easily
☐ Cancer	☐ Chemo / Radiation	☐ Chest Pain	☐ Chronic Cough
☐ ColdSores/FeverBlist	☐ Contact Lenses	☐ COPD	☐ Diabetes
☐ Dizziness / Fainting	☐ Emphysema	☐ Epilepsy/Seizures	☐ Excessive Bleeding
☐ Glaucoma	☐ Hay Fever	☐ Head Injuries	☐ Heart Attack
☐ Heart Murmur	☐ Heart Surgery	☐ Hemophilia	☐ Hepatitis
☐ High Blood Pressure	☐ HIV / AIDS	☐ Jaundice	☐ Kidney Disease
☐ Kidney Trouble	☐ Liver Disease	☐ Mitral ValveProlapse	☐ Nervous/Anxious
☐ NeurologicalDisorder	☐ On Blood Thinners	☐ Pacemaker	☐ Parkinson's Disease
☐ Psychiatric Care	☐ Psychological Care	☐ Respiratory Problems	☐ Restricted Diet
☐ Rheumatic Fever	☐ Sickle Cell Disease	☐ Sinus Problems	☐ Sleep Apnea
☐ STD / HPV	☐ Stomach Problems	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ xOther Explain Below

☐ 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

Do you smoke, vape, or use chewing tobacco? Please check all that apply.

☐ Smoke ☐ Vape ☐ Chew

Do you take antibiotic PREMEDICATION (premed) for your dental visits? If yes, please explain below. (Give date of surgery, or date you were diagnosed with the condition for which you premed. Also, tell us what you take and how it is taken. For example: Amoxicillin 500mg, 4 tablets 1 hour before dental appointment.) *

◯ Yes ◯ No

PREMEDICATION

_____

_____

MEDICATIONS Are you taking any prescription OR non-prescription medications, including regular doses of aspirin or birth control pills? If yes, please list below. *

◯ Yes ◯ No

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

Have you, or are you taking any Bisphosphonate drug used to treat osteoporosis or Paget's disease? Examples; Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Prolia etc. If yes, please enter the drug in the medication list above. *

◯ Yes ◯ No

Have you ever taken prescription medications for weight-loss (diet pills) such as Fen-Phen (Fenfluramine-Phentermine), Pondimen (Fenfluramine) or Redux (Dexfenfluramine)? If yes, please list in medication list above. *

◯ Yes ◯ No

If you have taken any of the above (diet pills), did you have a medical exam for heart issues? ◯ Yes ◯ No

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

Name of your primary care physician and phone number:

Date of your last visit: _____

Name and phone number of preferred pharmacy:

In an emergency who should be notified? Please enter name and phone number below:

Describe any current medical treatment, recent hospitalizations and any recent or upcoming procedures/surgeries below:

☐ * **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.**

Response Date: _____

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COVID-19 Patient Screening Form

If you answer YES to any of these Questions, please explain in the box provided.

Patient Name: _____ * _____ * ____ _____

Last First MI Preferred Name

IN OFFICE USE ONLY Body Temperature _____

Have you received a COVID-19 Vaccine? * ◯ Yes ◯ No

Check which you have received: *

◯ None ◯ 1st Vaccine ◯ 1st & 2nd Vaccine ◯ Johnson & Johnson Vaccine

Do you have a fever or have you felt hot or feverish recently (within the past 14-21 days)? * ◯ Yes ◯ No

Are you having any shortness of breath or other difficulties breathing? * ◯ Yes ◯ No

Do you have a cough or a sore/scratchy throat? * ◯ Yes ◯ No

Have you had any flu-like symptoms, such as gastrointestinal upset, headache or fatigue within the past 14-21 days? * ◯ Yes ◯ No

Have you experienced recent loss of taste or smell? * ◯ Yes ◯ No

Are you, or have you been, in contact with any confirmed COVID-19 positive patients? If yes, provide the date of last contact with the person(s): *

◯ Yes ◯ No

Have you been in contact with anyone within the last 14-21 days who has been ill or who has had a fever? * ◯ Yes ◯ No

Response Date: _____