

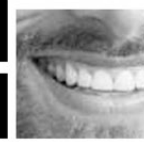
Jon D. Nickelsen, D.D.S.

523 North McLean Blvd.

Elgin, IL 60123

847-742-8811

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Medical History Form

Patient Name:
Last First MI Preferred Name

Address:

City State Zip Code

Have you been under medical care within the last 2 years?

Yes No

If so, for what?

Are you taking any medications?

If so, please list medications.

Are you allergic to any medication?

If so, please list medication you're allergic to:

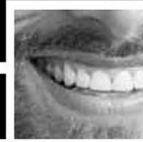
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Medical History Form

Indicate which of the following you have had or have at present:

- | | |
|--|--|
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemo Therapy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Bisphosphonate/Osteoporosis Therapy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cardiac Stent Placed | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis A & B | <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tobacco Use |

Women Only:

Are you pregnant?

Yes No

If so, how many months?

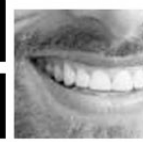
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Are you nursing?

Yes No

Are taking birth control?

Yes No

Response Date: