Time 9:06 AM | Richland Dentistry, PLC | Date 6/17/2015

MED HISTORY FORM

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Who is your Primary Care Physician?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Do you have a hearing, speech, vision, or mobility problem?	Yes No	If yes
Do you need any special accommodations for treatment? Explain	Yes No	If yes
Are you taking any medications, pills, drugs? List Name, Dosage, Frequency	Yes No	If yes
Are you taking or have you ever taken medication to control bone loss (Fosamax, Boniva, etc.)?	Yes No	If yes
Do you have an artificial joint, artificial heart valve, or congenital heart defect? Explain	Yes No	If yes
Do you require premedication before dental treatment? If yes, Specialist who initally prescribed	Yes No	If yes
Do you use tobacco? Type and how often	Yes No	If yes
Do you drink alcohol? How many drinks per week?	Yes No	If yes
Do you use recreational drugs? Explain	Yes No	If yes
Do you clench or grind your teeth? If yes, do you have a bitesplint/night guard?	Yes No	If yes
Do you prefer nitrous oxide (laughing gas) during dental treatment?	Yes No	

Are you allergic to any of the following?

☐ Acrylic	☐ Aspirin	☐ Codeine	☐ Latex
☐ Local Anesthetics	☐ Metal	☐ Penicillin	☐ Sulfa Drugs

Other? ☐ If yes

Women: Are you...

Pregnant?	Yes No	Nursing?	Yes No	Taking Oral Contraceptives?	Yes No

Do you have, or have you had any of the following?

Asthma	Yes No	Kidney Disease	Yes No	Arthritis	Yes No	Mental Illness	Yes No
Emphysema/COPD	Yes No	Frequent Urination	Yes No	Osteoporosis	Yes No	Alzheimer's Disease	Yes No
Tuberculosis	Yes No	Dialysis	Yes No	Artifical Joint	Yes No	Depression/Anxiety	Yes No
Shortness of Breath	Yes No	Excessive Thirst	Yes No	Back Problems	Yes No	Cancer of Any Type	Yes No
High Blood Pressure	Yes No	Stroke	Yes No	Adrenal/Pancreatic Disease	Yes No	Organ/Bone Marrow Transplant	Yes No
Low Blood Pressure	Yes No	Fainting Spells	Yes No	Hypoglycemia	Yes No	Lupus	Yes No
Angina/Chest Pains	Yes No	Epilepsy or Seizures	Yes No	Liver Disease	Yes No	Multiple Sclerosis	Yes No
Irregular Heartbeat	Yes No	Anaphylaxis	Yes No	Hepatitis A, B, or C	Yes No	Hemophlilia	Yes No
Damage to Heart Valves	Yes No	Nose or Sinus Problems	Yes No	Acid Reflux	Yes No	Sickle Cell Anemia	Yes No
Heart Valve Replacement	Yes No	Swollen Glands	Yes No	Ulcers	Yes No	Anemia	Yes No
Pacemaker	Yes No	Oral Cancer	Yes No	Crohn's Disease	Yes No	AIDS/HIV Positive	Yes No
Congestive Heart Failure	Yes No	Frequent/Severe Headaches	Yes No	Irritable Bowel Syndrome	Yes No	Bruise/Bleed Easily	Yes No
Thyroid Disease	Yes No	Cold Sores/Fever Blisters	Yes No	Frequent Diarrhea	Yes No	Chemotherapy	Yes No
Diabetes	Yes No	Canker Sores	Yes No	Eating Disorder	Yes No	Radiation Therapy	Yes No

Have you ever had any serious illness not listed? Yes No If yes

Comments

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____