Richland Creek Family Dentistry

Medical History

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

	Yes	No	If Yes, specify…
Are you under a physician's care now?	☐	☐	
Have you ever been hospitalized or had a major operation?	☐	☐	
Have you ever had a serious head or neck injury?	☐	☐	
Are you taking any medications, pills, or drugs? If yes, please list…	☐	☐	
Have you taken the weight loss medicine, Phen-Fen or Redux?	☐	☐	
Have you ever taken bisphosphonates (i.e. Fosamax, Boniva, Actonel, etc.)?	☐	☐	
Do you use tobacco?	☐	☐	

Women: Are you… ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Other (*Please Specify*):			
Do you use any controlled substances or recreational drugs? ☐ No ☐ Yes (Please Specify):			

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

Y N AIDS/HIV Positive	**Y N** Alzheimer's Disease	**Y N** Anemia	**Y N** Arthritis/Gout	**Y N** Artificial Heart Valve
Y N Artificial Joint	**Y N** Asthma	**Y N** Blood Thinners	**Y N** Breathing Problems	**Y N** Bruise Easily
Y N Cancer	**Y N** Chemotherapy	**Y N** Chest Pains	**Y N** Cold Sores/Fever Blisters	**Y N** Congenital Heart Disorder
Y N Dry mouth	**Y N** Diabetes	**Y N** Drug Addiction	**Y N** Easily Winded	**Y N** Emphysema
Y N Epilepsy/ Seizure	**Y N** Fainting/ Dizziness	**Y N** Frequent Cough	**Y N** Frequent Diarrhea	**Y N** Frequent Headaches
Y N Glaucoma	**Y N** Heart Attack	**Y N** Hepatitis	**Y N** Herpes	**Y N** High Blood Pressure
Y N High Cholesterol	**Y N** Hives or Rash	**Y N** Irregular Heartbeat	**Y N** Kidney Problems	**Y N** Leukemia
Y N Liver Disease	**Y N** Low blood sugar	**Y N** Lung Disease	**Y N** Mitral Valve Prolapse	**Y N** Osteoporosis
Y N Pacemaker	**Y N** Pain in Jaw Joints	**Y N** Psychiatric Care	**Y N** Radiation	**Y N** Scarlet/ Rheumatic Fever
Y N Shingles	**Y N** Sickle Cell Disease	**Y N** Sinus Trouble	**Y N** Stroke	**Y N** Swelling of Limbs
Y N Thyroid Disease	**Y N** Tonsillitis	**Y N** Tuberculosis	**Y N** Tumors or Growths	**Y N** Ulcers
	Any serious illness not listed, please specify:			

Comments:

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____