River Ridge Dental

Medical History

Physician's Name ______________________________ Physician's Phone ________________

Are you under a physician's care now? Yes No If yes, for what? ________________

Have you ever been hospitalized or had a major operation? Yes No If yes, for what? ________________

Have you ever had a serious head or neck injury? Yes No

Do you take, or have you taken bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Didronel, Boniva)? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No If yes, what type and how often? ________________

Do you use controlled substances? Yes No

Women: Are you pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Have you ever been required to take antibiotic premedication prior to dental procedures? Yes No

Do you have, or have you had, any of the following? Please circle all that apply.

Acid Reflux	Chemotherapy	Frequent Diarrhea	Irregular Heartbeat	Scarlet Fever
AIDS/HIV positive	Chest Pains	Frequent Headaches	Jaundice	Shingles
Alzheimer's Disease	Cold Sores	Genital Herpes	Kidney Problems	Sickle Cell Disease
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sinus Trouble
Anemia	Convulsions	Hay fever	Liver Disease	Stroke
Angina	Cortisone Medication	Heart Attack / Failure	Low Blood Pressure	Swelling of limbs
Arthritis/Gout	Diabetes	Heart Murmur	Lung Disease	Thyroid disease
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Mitral Valve Prolapse	Tonsillitis
Artificial Joint	Easily Winded	Heart Trouble / Disease	Parathyroid Disease	Tuberculosis
Asthma	Emphysema	Hemophillia	Psychiatric Care	Tumors or Growths
Blood disease	Epilepsy or seizures	Hepatitis A	Radiation Treatments	Ulcers
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Recent Weight Loss	
Breathing Problem	Excessive Thirst	High Blood Pressure	Renal Dialysis	
Bruise Easily	Fainting Spells/Dizziness	Hives or Rash	Rheumatic Fever	
Cancer	Frequent Cough	Hypoglycemia	Rheumatism	

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

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other ____

Are you currently taking any medications, vitamins or supplements? If yes, please list all and reason for taking:

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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 my medical status.

Signature of patient, parent or guardian ______________________________ Date ______________