Medical History UPDATE DATE _______________

Name____Preferred Name________________

Yes	No	
☐	☐	1. Are you currently under medical treatment? ___________________________________
☐	☐	2. Within the last 5 years, have you ever been hospitalized for any surgical operation or serious illness? If so, please explain____
☐	☐	3. Do you have a cardiac pacemaker?
☐	☐	4. Do you use tobacco products?
☐	☐	5. Do you use controlled substances?
☐	☐	6. Do you take blood thinners (i.e. COUMADIN, PLAVIX, PRADAXA, EFFIENT, BRILINTA)
☐	☐	7. Are you taking any non-prescription medication(s)? If so, please list _______________

____

☐	☐	8. Do you take any prescription medication(s)? If so, please list_______________________

____

9. Please circle if you are allergic to or have had any reactions to the following:

Any metals (e.g. nickel, mercury, etc)   Aspirin   Barbiturates   Codeine   Latex rubber

Local anesthetics (e.g. Novocain)   Penicillin   Sedatives   Sulfa Drugs   Other___________________

10. Women only:	Yes	No
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐

11. Do you have or have you had any of the following?

	Yes	No		Yes	No
HIV Disease	☐	☐	Emphysema	☐	☐
Dialysis	☐	☐	Epilepsy/Convulsions	☐	☐
Heart Murmur	☐	☐	Crohn's Disease	☐	☐
Joint Replacement or Implant	☐	☐	Glaucoma	☐	☐
Kidney Diseases	☐	☐	Heart Attack	☐	☐
Lupus	☐	☐	Heart Disease/Angina	☐	☐
Mitral Valve Prolapse	☐	☐	Heart Surgery (Cath, Bypass)	☐	☐
Rheumatic Fever	☐	☐	Jaundice/Hepatitis type _______	☐	☐
Spleen Removal	☐	☐	High Blood Pressure	☐	☐
			Liver Disease	☐	☐
Allergies/Hay Fever	☐	☐	Chemo/Radiation Therapy	☐	☐
Anemia	☐	☐	Sexually Transmitted Infection	☐	☐
Arthritis	☐	☐	Thrombocytopenia	☐	☐
Asthma	☐	☐	Stroke	☐	☐
Cancer type _______________	☐	☐	Thyroid Problems	☐	☐
Diabetes type ______________	☐	☐	Tuberculosis	☐	☐
Herpes	☐	☐	GERD (Heart burn)	☐	☐

Any Conditions not listed ____

Please see other side ------------------------→

Medical History, continued.

Physician ______________________________________ **Office Phone** _________________________

Do you have or have you ever had a history of the following conditions:

	Yes	No
Multiple Myeloma	☐	☐
Metastatic Cancer	☐	☐
Breast Cancer	☐	☐
Lung Cancer	☐	☐
Paget's Disease	☐	☐
Osteoporosis	☐	☐
Osteomalacia	☐	☐
Osteonecrosis of the jaws	☐	☐

Do you take or have you ever taken any of the following medications or any other Bisphosphonate medication?

	Yes	No
Zometa	☐	☐
Aredia	☐	☐
Fosamax	☐	☐
Boniva	☐	☐
Actonel	☐	☐
Didronel	☐	☐
Skelid	☐	☐
Prolia	☐	☐

12. Dental History for All Patients:

When was your last dental visit? ____

What was the reason for that visit? ____

Have you had injury to teeth or face? Explain: ____

Do you think you have clenching/grinding issue? ____

Are happy with appearance of your teeth? ____

Do you think you could benefit from braces? _______ **Cosmetics?** _________ **Whitening?** ___________

Do you wish to discuss something privately with the dentist? _____________________________________

Do you snore or have sleeping problems? ____

13. Administrative and social questionnaire.

Where did hear about us? ____

Why did you choose our office? ____

Did you have a chance to visit our website at www.richlandnedental.com? ______________________________

if so, did you find it helpful (in what)? ____