The Riverfront Dentist

PT ID

Patients Name_____ Birth Date_____ Age_____

Physician_____ Name of Clinic/Phone_____/(_____)_____ Last visit _____

5 HEALTH HISTORY – Have you had any of the following medical conditions? Please check "Yes" or "No"

1.CARDIOVASCULAR

Heart Disease or attack	☐ Yes	☐ No
Angina pectoris/chest pain	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Congenital heart defect or lesion	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No
Heart pacemaker	☐ Yes	☐ No
Heart Surgery or transplant	☐ Yes	☐ No
Other heart problems	☐ Yes	☐ No
Stroke/Aneurysm	☐ Yes	☐ No

2.HEMATOLOGIC

Anemia	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Sickle cell (anemia) disease	☐ Yes	☐ No
Bleed longer than normal	☐ Yes	☐ No

3. NEURAL AND SENSORY

Glaucoma	☐ Yes	☐ No
Psychiatric treatment	☐ Yes	☐ No
Fainting and dizzy spells	☐ Yes	☐ No
Epilepsy, seizures or convulsions	☐ Yes	☐ No
Down's syndrome	☐ Yes	☐ No
Cognitive disorder	☐ Yes	☐ No

4. GASTROINTESTINAL

Colitis/Ulcers	☐ Yes	☐ No
Crohn's disease	☐ Yes	☐ No
Eating disorder	☐ Yes	☐ No
Hepatitis - Type _____	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
GERD (gastric reflux)	☐ Yes	☐ No

5. RESPIRATORY

Sinus trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

6. DERMAL MUCOCUTANEOUS MUSCULOSKELETAL

Arthritis	☐ Yes	☐ No
Artificial joint	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Cold sore	☐ Yes	☐ No
Canker sore	☐ Yes	☐ No
Colored or discolored areas in mouth	☐ Yes	☐ No

7. ENDOCRINE

Diabetes - Type_____	☐ Yes	☐ No

8. URINARY - SEXUALLY TRANSMITTED

Dialysis/transplant	☐ Yes	☐ No
STD	☐ Yes	☐ No
HIV positive (AIDS)	☐ Yes	☐ No

9. OTHER CONDITIONS

Drug or alcohol addiction (recovering or current)	☐ Yes	☐ No
Tumor or cancer	☐ Yes	☐ No
Radiation therapy	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Bisphosphonate (Fosomax, Actonel, Boniva, Zometa, Aredia, etc.)	☐ Yes	☐ No
Take Antibiotics prior to Dental appointments	☐ Yes	☐ No
Disease, problem or condition not listed	☐ Yes	☐ No

If yes, list _____

10. ARE YOU

Taking medications now or Within the past year such as		
Blood thinners	☐ Yes	☐ No
Cortisone	☐ Yes	☐ No
Nitroglycerine	☐ Yes	☐ No

Other/Additional-list below

_____

_____

_____

_____

Do you currently smoke or use the following tobacco products?

☐ Cigarettes _____ Packs/Day? ☐ Cigars ☐ Pipe ☐ Chew ☐ None

Have you used tobacco products in the past? ☐ Yes ☐ No How long ago? _____

Have you had any serious illness, hospitalization or accident? ☐ Yes ☐ No

If yes, please explain_____

WOMEN:

Are you pregnant	☐ Yes	☐ No	Due Date_____
Taking birth control pills?	☐ Yes	☐ No	
Are you nursing?	☐ Yes	☐ No	

MEDICATIONS

List any medications you are currently taking: _____

_____

_____

Pharmacy Name_____ Phone (_____)_____

DRUG ALLERGIES

☐ Codeine	☐ Other:
☐ Latex	_____
☐ Local Anesthetic	_____
☐ Penicillin	☐ No known allergies

COMMENTS

Patient or Guardian's Signature _____ **Date** _____