Time 10:46 AM | Ramsey Dental Group | Date 7/26/2019

Medical History

Patient Name: | Birth Date: | Date Created:

Are you under a physician's care now?	◯ 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
Are you taking any medications, pills, drugs or supplements?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you taking anticoagulants (Blood thinners)?	◯ Yes ◯ No	If yes
Do you take or have you taken Phen-Fen, Redux or Pondimin?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes
Do you take immunosuppressants, i.e., Bremicade, Embrel, Humira or any others?	◯ Yes ◯ No	If yes
Do you have a cold, fever or sore throat?	◯ Yes ◯ No	If yes

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 ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other Antibiotics
☐ Latex

Other? ☐ If yes

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

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

AIDS/HIV Positive ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Rheumatisn ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	H.P.V. ◯ Yes ◯ No	Sexually Transmitted Diseases ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heart Beat ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Sleep Apnea ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Poryphyria ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Radiations Treatments ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Cortisone Medicine ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Acid Reflux/G.E.R.D. ◯ Yes ◯ No			

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:

X **Date:**_____