R.L. Daschbach Dentistry & Associates

Today's Date: _____

Patient Medical History

Name: _____ Birth date: _____

Physician's Name: _____ Physician's Phone number: _____

Cardiologist's Name: _____ Cardiologist's Phone number: _____

Pharmacy Name: _____ Pharmacy's Phone number: _____

Patient's Email Address:_____ Best Number to Reach You:_____

Emergency Contact:_____ Emergency Contact Phone:_____

Please circle appropriate response:

Are you under a physician's care now?	YES	NO	*If yes please explain:*_____ _____
Do you take an anti-coagulant? (a blood thinner)	YES	NO	*If so what:*_____
Have you ever taken or received any medications contain bisphosophonates? (ie. Fosamax, Boniva)	YES	NO	*If yes please explain:*_____ _____
Have you taken a phosphodiesterase? (i.e. Viagra, etc)?	YES	NO	
Do you take, or have you taken Phen-Fen?	YES	NO	
Are you on a special diet?	YES	NO	*If yes please explain:*_____
Do you use tobacco?	YES	NO	*How Often:*_____
Do you use controlled substances?	YES	NO	*If yes please explain:*_____

Have you had or have at the present any of the following: (*Please circle option that applies*)

Y	N	Angina Pectoris	Y	N	Hearing Impairment
Y	N	Atrial Fibrillation	Y	N	Hemophilia/Abnormal Bleeding
Y	N	Alcoholism/Drug Addiction	Y	N	Hepatitis/TYPE_____
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Artificial Bone/Joint/Valves/Spinal Fusion	Y	N	Liver Disease
Y	N	Arthritis/Rheumatoid Arthritis/Lupus	Y	N	Low Blood Pressure
Y	N	Asthma/Inhaler	Y	N	HIV+/AIDS
Y	N	Anxiety/Mood Disorder	Y	N	Hypoglycemia
Y	N	Bacterial Endocarditis	Y	N	Kidney Problems/Renal Dialysis
Y	N	Blood Transfusion	Y	N	Mental or Physical Impairment
Y	N	Cancer/Chemotherapy/Radiation Treatment Type:_____	Y	N	MRSA
Y	N	C-Dif	Y	N	Pins, Plates or Screws
Y	N	Congenital Heart Defect	Y	N	Rheumatic Fever/Scarlet Fever
Y	N	Diabetes TYPE I or TYPE II	Y	N	Seasonal Allergies/Hay Fever
Y	N	Eating Disorders	Y	N	Shingles
Y	N	Emphysema/COPD/Difficulty Breathing	Y	N	Sickle Cell Disease/Traits
Y	N	Epilepsy/Seizures/Fainting Spells	Y	N	Sinus Problems
Y	N	Fever Blisters/Herpes	Y	N	Stomach Problems/Acid Reflux/GERD
Y	N	Heart Attack/Stroke/Congestive Heart Failure	Y	N	STD/HPV/other infectious disease
Y	N	Heart Murmur/Mitral Valve Prolapse	Y	N	Thyroid Problems/Adrenal Pituitary
Y	N	Heart Surgery/Pacemaker	Y	N	Transplant
			Y	N	Tuberculosis(TB)/When?_____

Women: Are you…

Pregnant/trying to get pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO

Do you take birth control pills? ☐ YES ☐ NO * Please be aware that antibiotics can alter effectiveness of birth control

Are you allergic to any of the following? ☐ YES ☐ NO

☐ Aspirin ☐Penicillin ☐Codeine ☐NSAIDS (IBPROPHEN) ☐Metals ☐ Sulfa Drugs

☐Local Anesthetic (Novocaine) ☐Food Allergies_____ ☐ Other, please explain_____

Are you taking any medications, herbal supplements or vitamins/minerals?	YES	NO	*Please list:*_____ _____ _____ _____ _____ _____
Please list any surgeries you have had?			*Please list: (Include Year of surgery)* _____ _____ _____ _____

Do you have any disease, condition or problem not listed above that you think we should know about?

_____

_____

_____

_____

Authorization & Consent

I acknowledge that I am responsible for informing the doctor about any changes in my medical status prior to treatment. I understand that providing incorrect information can be dangerous to my (or patients' health).

I understand that my health history information will be used as necessary for diagnosis or treatment by the doctors. I hereby authorize and request the performance of dental services for:

X_____

PRINT NAME OF PATIENT

X_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes or dental treatment.

X_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

Clinician Only:

Doctor's Signature:_____ Date:_____

Updated: _____ Initial/Date Updated: _____ Initial/Date Updated: _____ Initial/Date Updated: _____ Initial/Date

Updated: _____ Initial/Date Updated: _____ Initial/Date Updated: _____ Initial/Date Updated: _____ Initial/Date