Rice Family Dentistry
Medical History Form

Patient Name:_____ **DOB:**_____

Although dental personnel primarily treat the area in the and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking,could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? O Yes O No
If yes _____

Have you ever been hospitalized or had a major operation? O Yes O No
If yes _____

Have you ever had a serious head or neck injury? O Yes O No
If yes _____

Do you take any medications, pills, or drugs? O Yes O No
If yes_____

Do you take, or have you taken, Phen-Fen or Redux? O Yes O No
If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? O Yes O No
If yes_____

Are you on a special diet? O Yes O No

Do you use tobacco or vape? O Yes O No

Do you use controlled substances? O Yes O No
If yes_____

Women are you…

O Pregnant/Trying to get Pregnant? O Nursing? O Taking Oral Contraceptives?

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Sulfa Drugs

O Local Anesthetics O Other? If yes _____

_____

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

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No
Cold Sore/Fever Blisters	O Yes O No	Heart Murmur	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pacemaker	O Yes O No
Convulsions	O Yes O No	Heart Trouble Disease	O Yes O No

Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O No
Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O No
Herpes	O Yes O No	Rheumatic Fever	O Yes O No
High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Hives or Rash	O Yes O No	Shingles	O Yes O No
Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Liver Disease	O Yes O No	Stroke	O Yes O No
Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O No
Osteoporosis	O Yes O No	Tuberculosis	O Yes O No
Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
		Yellow Jaundice	O Yes O No

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

Comments:

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: _____