Redmond Way Dentistry
Patient's Medical Information

Patient's Name_____ Date of Last Physical Exam_____

Physician's Name_____ Physician's Phone # _____

Patient's Medical History

1. Are you under medical treatment now?.....YES NO

   If so, what?_____
2. Have you been hospitalized for any surgical operations or serious illness?.....YES NO

   If so, what?_____
3. Are you taking any medicines including non-prescription medicine?.....YES NO

   If so, what?_____
4. Have you ever been diagnosed with obstructive sleep apnea?.....YES NO

   If so, when?_____

Allergies to Medicines

☐ **No Known Allergies**

Are you allergic to or have you had any reactions to the following?

☐ Local Anesthetics (i.e. Novocain) ☐ Sulfa Drugs ☐ Codeine ☐ Latex ☐ Sedatives

☐ Penicillin / Amoxicillin ☐ Ibuprofen ☐ Barbiturates ☐ Aspirin

☐ Other _____

Please check the boxes if you have or have had any of the following

☐ Joint Replacement/Implants/Screws/Pins ☐ Anemia ☐ Cancer / Radiation Therapy

☐ History of Tobacco Use ☐ Emphysema ☐ Kidney / Liver Disease

☐ Heart Murmur ☐ Cardiac Pacemaker ☐ Angina / Chest Pains

☐ Heart Attack / Heart Disease ☐ Rheumatic Fever ☐ Hepatitis / Jaundice

☐ High Blood Pressure ☐ Fainting / Seizures ☐ Epilepsy / Convulsions

☐ Low Blood Pressure ☐ Recent Weight Loss ☐ Leukemia

☐ Asthma ☐ Diabetes ☐ Thyroid Problems

☐ Respiratory Problems ☐ Tumors or Growths ☐ Stomach Troubles / Ulcers

☐ Stroke ☐ Hay Fever / Seasonal Allergies ☐ Intestinal Disease

☐ Tuberculosis ☐ Weight Reduction Surgery ☐ AIDS / HIV Infection

☐ Night Sweats accompanied by weight loss or cough ☐ Wounds that heal slowly or present with other complications

☐ Have you been treated for Alcohol or Chemical dependency? ☐ Snoring while sleeping

Women Only: ☐ Pregnant or think you may be pregnant ☐ Nursing ☐ Taking Birth Control Pills

What is your main reason for visiting Redmond Way Dentistry?_____

_____

Patient/Guardian Signature:_____ Date:_____

Dentist's Signature:____ **Date:**________________________