Redmond Way Dentistry Medical History Form

Patient's Name _____

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. Are you required to pre-medicate before dental treatment? _____YES NO
   If so, what? _____

Treating Physician's Name : _____ Phone Number _____
Date of Last physical Exam : _____

Allergies to Medicines

Are you allergic to or have you had any reactions to the following? ☐ No Known Allergies

□ Local Anesthetics (i.e. Novocain)
□ Latex
□ Ibuprofen
□ Sulfa Drugs
□ Sedatives
□ Barbiturates
□ Codeine
□ Penicillin / Amoxicillin
□ Aspirin
□ Other _____

Medical Conditions

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

□ AIDS / HIV Infection
□ Anemia
□ Angina / Chest Pains
□ Asthma
□ Cancer / Radiation Therapy
□ Cardiac Pacemaker
□ Diabetes
□ Emphysema
□ Epilepsy / Convulsions
□ Fainting / Seizures
□ Have you been treated for Alcohol or Chemical dependency?
□ Hay Fever / Seasonal Allergies
□ Heart Attack / Heart Disease
□ Heart Murmur
□ Hepatitis / Jaundice
□ High Blood Pressure
□ Intestinal Disease
□ Joint Replacement / Implants / Screws / Pins
□ Kidney / Liver Disease
□ Leukemia
□ Low Blood Pressure
□ Mitral Valve Prolapse
□ Night Sweats accompanied by weight loss or cough
□ Recent Weight Loss
□ Respiratory Problems
□ Rheumatic Fever
□ Stomach Troubles / Ulcers
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Tumors or Growths
□ Weight Reduction Surgery
□ Wounds that heal slowly or present with other complications

***WOMEN ONLY*:** □ Pregnant or think you may be pregnant □ Nursing □ Taking Birth Control Pills

What is your main reason for visiting Redmond Way Dentistry?

_____

Signature:_____ **Date:**_____

Dentist's Signature:_____ **Date:**_____