MEDICAL HISTORY

River City Dental

Patient Name:	Date of Birth:

Please check any of the following problems/conditions that apply to you:

AIDS/HIV	☐	Epilepsy	☐	Sinus Problems	☐
Alzheimer's Disease	☐	Fainting/Dizziness	☐	Sleep Apnea	☐
Anaphylaxis	☐	Herpes/ Cold Sores	☐	Stroke	☐
Angina (Chest Pain)	☐	Heart Conditions	☐	Thyroid Disease	☐
Arthritis	☐	Heart Murmur	☐	Tonsillitis (Frequent)	☐
Artificial Heart Valve	☐	Hepatitis A,B,C,D	☐	Tuberculosis (TB)	☐
Artificial Joints	☐	High/Low Blood Pressure	☐	**Use of any of the following**:	
Asthma	☐	HPV (Human Papilloma Virus)	☐	Birth Control	☐
Bacterial Endocarditis	☐	Kidney Disease	☐	Drug Use	☐
Cancer	☐	Liver Disease	☐	Drug Addiction (past)	☐
Chemotherapy	☐	Pacemaker	☐	Tobacco products	☐
Crohn's Disease/ IBS	☐	Radiation (Head/Neck)	☐	Marijuana use	☐
Diabetes	☐	Seizures	☐	**Pre- Med Needed?**	☐

Please explain any of the above further, or if you have any other conditions not listed: _____

_____

_____

Have you ever taken Bisphosphonates, or other medications for **Osteoporosis**? Yes ☐

Are you allergic or have you reacted adversely (hives/ rash) to any of the following medications?

Aspirin	☐	Percodan	☐	Tetracycline	☐	Penicillin	☐
Darvon	☐	Latex	☐	Codeine	☐	Sulfa	☐
Nitrous Oxide	☐	Local Anesthetic	☐	Erythromycin	☐	Valium	☐
Acrylic	☐	Metal	☐	Other	_____		

Please list medications you are currently taking (including supplements)

_____

_____

_____

_____

_____

Please List any major surgeries or head/neck injuries you have had.

_____

_____

Are you under a pain contract? Y / N **Physician it is through & Ph #:** _____

Are you under a physician's care? Y / N What for? **Physician's Name** **Phone Number**

_____ _____

Women: Are you pregnant, trying to become pregnant, or breastfeeding? Y / N Due Date?_____

I understand that providing incorrect information may be dangerous to my health. It is my responsibility to inform my dental provider of any changes in medical status. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____

Patient Signature **Date** **Dentist Signature**