MEDICAL & DENTAL HISTORY

Rauch Dental ASSOCIATES

Patient Name _____ Date of Birth _____ Date _____

This medical history is confidential. You may be asked additional questions concerning your responses. This information helps us to provide you with the best possible care. Please answer the following questions to the best of your knowledge. Thank you

Emergency Contact _____ Relationship: _____ Phone #_____

Are currently under the care of a physician? o Yes o No Date of last visit _____

Physician/Specialist or Group Name _____ Phone # _____

Former Dentist _____ Date of last dental cleaning/appointment _____

Chief Complaint: What Brings you into our office today? _____

Do you have, or have you <u>had</u> any of the following?

Y	N		Y	N		Y	N		Y	N	
o	o	Angina (Chest Pain)	o	o	Anemia	o	o	Crohn's Disease	o	o	ADHD / ADD
o	o	Arrhythmias	o	o	[Low] Blood Pressure	o	o	Diabetes (Circle) I II	o	o	Dental Anxiety
o	o	Artificial Heart Valve*	o	o	[High] Blood Pressure	o	o	Parathyroid Disease	o	o	Autism
o	o	Congenital Heart Disorder	o	o	Bruise Easily	o	o	Rheumatic Fever	o	o	Depression
o	o	(Infective) Endocarditis*	o	o	Hemophilia	o	o	SLE / Lupus	o	o	Neurological Condition
o	o	Heart Attack / Failure	o	o	Other Bleeding Problem	o	o	Thyroid Disease	o	o	Frequent Headaches
o	o	Heart Defect*	o	o	Artificial/Replaced Joint*	o	o	Cirrhosis	o	o	Fainting Spells
o	o	Mitral Valve Prolapse	o	o	Arthritis / Gout	o	o	Hepatitis (Circle) B C	o	o	Acid Reflux / GERD
o	o	Heart Murmur	o	o	Osteoporosis	o	o	Other Liver Disease	o	o	Canker Sores
o	o	Pacemaker	o	o	Renal Dialysis	o	o	Herpes (Cold Sores)	o	o	Dry Mouth
o	o	Stroke	o	o	Other Kidney Disease	o	o	HPV	o	o	Eating Disorder
o	o	Shunt	o	o	Asthma	o	o	AIDS / HIV Positive			
o	o	Stent	o	o	COPD	o	o	Cancer			
o	o	Epilepsy	o	o	Emphysema	o	o	Chemotherapy			
o	o	Glaucoma	o	o	Tuberculosis	o	o	Radiation Treatment			

Woman Only: Are you..	
o	o Pregnant (trying to become)
o	o Nursing
o	o Taking Oral Contraceptive

*Condition may require premedication prior to dental

Have you ever had any other illness not listed: _____

List any surgeries (and associated complications):_____

Do you currently take, or has a doctor recommended you take an antibiotic "premedication" prior to dental treatment? o Yes o No

Allergies: Are you allergic to any of the following?

Y	N		Y	N		Y	N		Y	N		Y	N	
o	o	Latex	o	o	Local Anesthetic	o	o	Aspirin	o	o	Seasonal Allergies	o	o	Egg
o	o	Penicillin	o	o	Sulfa drugs	o	o	Codeine	o	o	Milk	o	o	Nuts
o	o	Other antibiotic: _____				o	o	Other _____						

Are you taking any of the following? o Anticoagulant (Coumadin, Plavix) o Bisphosphonate o Recreational Drugs

Do you smoke or use tobacco products? If so how often, and what type _____

List all medications you are taking and dosage:

_____ _____ _____

_____ _____ _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. If there is any changes in my medical status I will inform the dentist.

Signature of Patient or Guardian_____ Date _____

Stop Writing Here

Medical History Update

Date ____________________________

Have there been any surgeries, procedures or changes in your health since your last dental appointment? ○ Yes ○ No

For what conditions? ____

List any new medications or changes in medications: ____

____

____

Signature ____________________________________

Date ____________________________

Have there been any surgeries, procedures or changes in your health since your last dental appointment? ○ Yes ○ No

For what conditions? ____

List any new medications or changes in medications: ____

____

____

Signature ____________________________________

Date ____________________________

Have there been any surgeries, procedures or changes in your health since your last dental appointment? ○ Yes ○ No

For what conditions? ____

List any new medications or changes in medications: ____

____

____

Signature ____________________________________

Date ____________________________

Have there been any surgeries, procedures or changes in your health since your last dental appointment? ○ Yes ○ No

For what conditions? ____

List any new medications or changes in medications: ____

____

____

Signature ____________________________________

Date ____________________________

Have there been any surgeries, procedures or changes in your health since your last dental appointment? ○ Yes ○ No

For what conditions? ____

List any new medications or changes in medications: ____

____

____

Signature ____________________________________

Date ____________________________

Have there been any surgeries, procedures or changes in your health since your last dental appointment? ○ Yes ○ No

For what conditions? ____

List any new medications or changes in medications: ____

____

____

Signature ____________________________________