Medical History

RacineDentalGroup S.C.

Smile after beautiful smile since 1969.

Name _____ Date of birth _____

Gender: _____

In the following questions, answer yes or no, whichever applies.
Your answers are for our records only and will be considered confidential.

Medical Doctor _____ Dr. phone # _____

Date of last physical exam _____

Do you have or have you ever had?:

Abnormal bleeding.....Y❍ N❍
Alcoholism/drug addiction..... Y❍ N❍
Anemia or blood disorders..... Y❍ N❍
Arthritis..... Y❍ N❍
Asthma..... Y❍ N❍
Cancer/tumor (Type:_____) Y❍ N❍
Diabetes (HbA1c #:_____)..... Y❍ N❍
Emphysema or COPD..... Y❍ N❍
Epilepsy, seizures.....Y❍ N❍
Fainting spells.....Y❍ N❍
Glaucoma..... Y❍ N❍
Herpes or other STD ..... Y❍ N❍
HIV..... Y❍ N❍
Immune deficiency or lupus..... Y❍ N❍
Kidney disease..... Y❍ N❍

Liver disease or hepatitis A, B, C ..... Y❍ N❍
Osteoporosis..... Y❍ N❍
Radiation Therapy..... Y❍ N❍
Sinus condition..... Y❍ N❍
Seizure disorder/Epilepsy..... Y❍ N❍
Stomach ulcers ..... Y❍ N❍
Thyroid disease .....Y❍ N❍
TMJ problems..... Y❍ N❍
Atrial fibrillation (A-fib) ..... Y❍ N❍
Angina (chest pain)..... ..... Y❍ N❍
Previous Heart attack / TIA/ Stroke ..... Y❍ N❍
Heart surgery.....Y❍ N❍
Heart valve replacement..... Y❍ N❍
Pacemaker/Defibrillator.....Y❍ N❍
Stents in heart or other vessels.....Y❍ N❍

High blood pressure.....Y❍ N❍
Loud snoring ..... Y❍ N❍
Daytime fatigue, tired..... .....Y❍ N❍
Restless sleep..... Y❍ N❍
Clenching/grinding during sleep .... Y❍ N❍
GERD/acid reflux..... Y❍ N❍
Xerostomia (dry mouth).....Y❍ N❍

Depression.....Y❍ N❍
Anxiety or phobia.....Y❍ N❍
Alzheimer's Disease.....Y❍ N❍
Dementia.....Y❍ N❍
Autism Spectrum Disorder.....Y❍ N❍
Legally Deaf.....Y❍ N❍
Legally Blind.....Y❍ N❍

Do you have any disease, condition or problem not listed above?_

Have you been diagnosed with sleep apnea? YES ❍ NO ❍ Do you wear a CPAP? YES ❍ NO ❍

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? YES ❍ NO ❍ Date _____

Have you been told you need antibiotics prior to a dental visit? YES ❍ NO ❍

Female Patients:

Are you pregnant, or is there any chance you might be pregnant? YES ❍ NO ❍ Due date:_____

Nursing? YES ❍ NO ❍

Social History:

Do you smoke or use a vap/e-cig? YES ❍ NO ❍ If yes, how much? _____

Do you use chewing tobacco? YES ❍ NO ❍ For how many years? _____

Do you currently use:

Alcohol? YES ❍ NO ❍ How often? _____

Marijuana? YES ❍ NO ❍ How often? _____

Recreational drug YES ❍ NO ❍ How often? _____

Patient Name: «FName» «LName» Date of Birth: «BirthDate»

Are you taking any of the following?:

Anticoagulants (blood thinners)..... Y❍ N❍
Medicine for high blood pressure..... Y❍ N❍
Cortisone or other steroids..... Y❍ N❍
Aspirin..... Y❍ N❍
Tranquilizers or antidepressants..... Y❍ N❍
Diabetes medication..... Y❍ N❍
Osteoporosis (bone density) drugs..... Y❍ N❍
Nitroglycerin..... Y❍ N❍

Allergic or reacted adversely to?:

Local anesthetics..... Y❍ N❍
Penicillin/Amoxicillin..... Y❍ N❍
Barbiturates, sedatives or sleeping pills..... Y❍ N❍
Sulfa..... Y❍ N❍
Codeine or other narcotics..... Y❍ N❍
Latex..... Y❍ N❍
Other_____
Other_____

Have you ever taken any of the following medications that are used for osteoporosis or bone cancer? YES ❍ NO ❍
Alendronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Zolendronate (Reclast or Zometa), Pamidronate (Aredia), Denosumab (Xgeva or Prolia).

List **all medications** including any over-the-counter medications, dietary or herbal supplements: _____

_____

_____

_____

_____

The above information that I have provided is true and correct to the best of my knowledge.

Patient Signature	Date	Doctor Signature	Date

Medical History Update

Patient Signature	Date	Doctor Signature	Date

Doctor comments: