Time 9:02 AM | Stone Ridge Dental, PLC | Date 4/30/2014

# Medical History _Vitals

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| Question | Answer | |
|---|---|---|
| Are you under a physician's care now? | Yes No | If yes |
| Have you ever been hospitalized or had a major operation? | Yes No | If yes |
| Have you ever had a serious head or neck injury? | Yes No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | Yes No | If yes |
| Are you on a special diet? | Yes No | |
| Do you use tobacco? | Yes No | |
| Do you use controlled substances? | Yes No | |
| Are you taking any medications, pills, or drugs? | Yes No | If yes |
| Do you need to premedicate prior to dental appointments? | Yes No | If yes |
| Are you currently taking a blood thinner? | Yes No | If yes |

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics

OtherAllergy? ☐ If yes

Do you have, or have you had, any of the following?

| Condition | Answer | Condition | Answer | Condition | Answer | Condition | Answer |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes No | Cortisone Medicine | Yes No | Hemophilia | Yes No | Radiation Treatments | Yes No |
| Alzheimer's Disease | Yes No | Diabetes | Yes No | Hepatitis A | Yes No | Anaphylaxis | Yes No |
| Drug Addiction | Yes No | Hepatitis B or C | Yes No | Renal Dialysis | Yes No | Anemia | Yes No |
| Herpes | Yes No | Rheumatic Fever | Yes No | Angina | Yes No | Emphysema | Yes No |
| High Blood Pressure | Yes No | Rheumatism | Yes No | Arthritis/Gout | Yes No | Epilepsy or Seizures | Yes No |
| High Cholesterol | Yes No | Scarlet Fever | Yes No | Artificial Heart Valve | Yes No | Excessive Bleeding | Yes No |
| Hives or Rash | Yes No | Shingles | Yes No | Artificial Joint | Yes No | Hypoglycemia | Yes No |
| Sickle Cell Disease | Yes No | Asthma | Yes No | Fainting Spells/Dizziness | Yes No | Irregular Heartbeat | Yes No |
| Blood Disease | Yes No | Kidney Problems | Yes No | Spina Bifida | Yes No | Blood Transfusion | Yes No |
| Leukemia | Yes No | Stomach/Intestinal Disease | Yes No | Liver Disease | Yes No | Stroke | Yes No |
| Low Blood Pressure | Yes No | Swelling of Limbs | Yes No | Cancer | Yes No | Glaucoma | Yes No |
| Lung Disease | Yes No | Thyroid Disease | Yes No | Chemotherapy | Yes No | Hay Fever | Yes No |
| Mitral Valve Prolapse | Yes No | Chest Pains | Yes No | Heart Attack/Failure | Yes No | Osteoporosis | Yes No |
| Tuberculosis | Yes No | Cold Sores/Fever Blisters | Yes No | Heart Murmur | Yes No | Pain in Jaw Joints | Yes No |
| Tumors or Growths | Yes No | Congenital Heart Disorder | Yes No | Heart Pacemaker | Yes No | Parathyroid Disease | Yes No |
| Ulcers | Yes No | Convulsions | Yes No | Heart Trouble/Disease | Yes No | Psychiatric Care | Yes No |

Do you have, or have you had within the past year?

| Condition | Answer | Condition | Answer | Condition | Answer |
|---|---|---|---|---|---|
| Frequent Headaches | Yes No | Bruise Easily | Yes No | Cortisone Medicine | Yes No |
| Recent Weight Loss | Yes No | Easily Winded | Yes No | Frequent Cough | Yes No |
| Yellow Jaundice | Yes No | Excessive Thirst | Yes No | Sinus Trouble | Yes No |
| Frequent Diarrhea | Yes No | Breathing Problems | Yes No | Tonsillitis | Yes No |

Have you ever had any serious illness not listed Yes No If yes

Comments:

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:___________

Vitals- Obtained by Provider

| Vital | Answer | |
|---|---|---|
| Blood Pressure | Yes No | If yes |
| Heart Rate | Yes No | If yes |