RICHARDSON
Dental Center

Patient's Name _____
Last First Initial Date of Birth

1. Are you under a physician's care? YES NO
2. Physician's Name _____Telephone: ( ) _____
3. When was your last complete physical exam? _____
4. Are you taking any medications or substances? YES NO
   Please list: _____
   _____
5. Are you allergic to any medications or substances? YES NO
   Please list: _____
6. Do you have any other allergies or hives? YES NO
7. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? YES NO
8. Are you sensitive to any metals or latex? YES NO
9. Are you pregnant or suspect you may be? YES NO
10. Do you use any birth control medications? YES NO
11. Have you ever had a serious illness or major surgery? YES NO
    Please list: _____
12. Have you ever taken Bisphosphonates, such as: Fosamax, Zometa or Aredia for bone tumors, excessive calcium in your blood or osteoporosis? YES NO
13. Do you smoke, chew, use snuff or any other forms of tobacco? YES NO
14. Do you regularly consume more than 1 or 2 alcoholic beverages a day? YES NO
15. Do you use controlled substances? YES NO
16. Do you have any disease, condition or problem not listed? If yes, please explain:_____ YES NO
    _____
17. Would you like to speak to the Doctor privately about any problems? YES NO

18. **Please check mark if you have had any of the following:**

___ AIDS/HIV positive
___ anemia
___ arthritis
___ artificial heart valve
___ artificial joints
___ asthma
___ bleed excessively
___cancer
___ chemo treatment
___ dental anxiety
___ diabetic
___ digestive problems
___ epilepsy
___ fainting/dizzy spells
___ glaucoma
___ heart disease
___ hepatitis
___ high blood pressure
___HPV
___ kidney problems
___ leukemia
___ liver problems
___ low blood
___ organ transplant
___ pacemaker
___ pre-med before dental appt
___ radiation treatments
___ respiratory disorder
___ stroke
___T.B.
___ tumor growth

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/GUARDIAN SIGNATURE _____ DATE_____
DENTIST SIGNATURE_____ DATE_____

Doctor/staff comments

_____
_____

MEDICAL HISTORY