RICHARDSON
Dental Center

Patient's Name _____
Last First Middle 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	___ digestive problems	___ liver problems
___ anemia	___ epilepsy	___ low blood pressure
___ arthritis	___ fainting/dizzy spells	___ organ transplant
___ artificial heart valve	___ glaucoma	___ pacemaker
___ artificial joints	___ heart disease	___ pre-med before dental appt
___ asthma	___ hepatitis	___ radiation treatments
___ blood thinner medication	___ high blood pressure	___ respiratory disorder
___cancer	___HPV	___ stroke
___chemo treatment	___ kidney problems	___T.B.
___diabetic	___ leukemia	___ tumor growth

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/GUARDIAN SIGNATURE _____ DATE_____
DENTIST SIGNATURE_____ DATE_____

Doctor/staff comments

_____
_____

MEDICAL HISTORY