

MEDICAL & DENTAL HISTORY

The Milford Dentist: Robert S. Rauch DDS PC

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? Yes 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 had any of the following?

- | | | | |
|---|--|--|---|
| Y N | Y N | Y N | Y N |
| <input type="radio"/> <input type="radio"/> Angina (Chest Pain) | <input type="radio"/> <input type="radio"/> Anemia | <input type="radio"/> <input type="radio"/> Crohn's Disease | <input type="radio"/> <input type="radio"/> ADHD / ADD |
| <input type="radio"/> <input type="radio"/> Arrhythmias | <input type="radio"/> <input type="radio"/> [Low] Blood Pressure | <input type="radio"/> <input type="radio"/> Diabetes (Circle) I II | <input type="radio"/> <input type="radio"/> Anxiety |
| <input type="radio"/> <input type="radio"/> Artificial Heart Valve* | <input type="radio"/> <input type="radio"/> [High] Blood Pressure | <input type="radio"/> <input type="radio"/> Parathyroid Disease | <input type="radio"/> <input type="radio"/> Autism |
| <input type="radio"/> <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> <input type="radio"/> Burse Easily | <input type="radio"/> <input type="radio"/> Rheumatic Fever | <input type="radio"/> <input type="radio"/> Depression |
| <input type="radio"/> <input type="radio"/> (Infective) Endocarditis* | <input type="radio"/> <input type="radio"/> Hemophilia | <input type="radio"/> <input type="radio"/> SLE / Lupus | <input type="radio"/> <input type="radio"/> Neurological Condition |
| <input type="radio"/> <input type="radio"/> Heart Attack / Failure | <input type="radio"/> <input type="radio"/> Other Bleeding Problem | <input type="radio"/> <input type="radio"/> Thyroid Disease | <input type="radio"/> <input type="radio"/> Frequent Headaches |
| <input type="radio"/> <input type="radio"/> Heart Defect* | <input type="radio"/> <input type="radio"/> Artificial/Replaced Joint* | <input type="radio"/> <input type="radio"/> Cirrhosis | <input type="radio"/> <input type="radio"/> Fainting / Seizures |
| <input type="radio"/> <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> <input type="radio"/> Arthritis / Gout | <input type="radio"/> <input type="radio"/> Hepatitis (Circle) B C | <input type="radio"/> <input type="radio"/> Acid Reflux / GERD |
| <input type="radio"/> <input type="radio"/> Heart Murmur | <input type="radio"/> <input type="radio"/> Osteoporosis | <input type="radio"/> <input type="radio"/> Other Liver Disease | <input type="radio"/> <input type="radio"/> Canker Sores |
| <input type="radio"/> <input type="radio"/> Pacemaker | <input type="radio"/> <input type="radio"/> Renal Dialysis | <input type="radio"/> <input type="radio"/> Herpes (Cold Sores) | <input type="radio"/> <input type="radio"/> Dry Mouth |
| <input type="radio"/> <input type="radio"/> Stroke | <input type="radio"/> <input type="radio"/> Other Kidney Disease | <input type="radio"/> <input type="radio"/> HPV | <input type="radio"/> <input type="radio"/> Eating Disorder |
| <input type="radio"/> <input type="radio"/> Shunt | <input type="radio"/> <input type="radio"/> Asthma | <input type="radio"/> <input type="radio"/> AIDS / HIV Positive | Woman Only: Are you...
<input type="radio"/> <input type="radio"/> Pregnant (trying to become)
<input type="radio"/> <input type="radio"/> Nursing
<input type="radio"/> <input type="radio"/> Taking Oral Contraceptive |
| <input type="radio"/> <input type="radio"/> Stent | <input type="radio"/> <input type="radio"/> COPD | <input type="radio"/> <input type="radio"/> Cancer | |
| <input type="radio"/> <input type="radio"/> Epilepsy | <input type="radio"/> <input type="radio"/> Emphysema | <input type="radio"/> <input type="radio"/> Chemotherapy | |
| <input type="radio"/> <input type="radio"/> Glaucoma | <input type="radio"/> <input type="radio"/> Tuberculosis | <input type="radio"/> <input type="radio"/> Radiation Treatment | |

*Condition may require premedication prior to dental

Have you ever had any other illness not listed: _____

List any surgeries (and associated complications): _____

Allergies: Are you allergic to any of the following?

- | | | | | |
|---|--|---|--|--|
| Y N | Y N | Y N | Y N | Y N |
| <input type="radio"/> <input type="radio"/> Latex | <input type="radio"/> <input type="radio"/> Local Anesthetic | <input type="radio"/> <input type="radio"/> Aspirin | <input type="radio"/> <input type="radio"/> Seasonal Allergies | <input type="radio"/> <input type="radio"/> Egg |
| <input type="radio"/> <input type="radio"/> Penicillin | <input type="radio"/> <input type="radio"/> Sulfa drugs | <input type="radio"/> <input type="radio"/> Codeine | <input type="radio"/> <input type="radio"/> Milk | <input type="radio"/> <input type="radio"/> Nuts |
| <input type="radio"/> <input type="radio"/> Other antibiotic: _____ | <input type="radio"/> <input type="radio"/> Other _____ | | | |

Are you taking any of the following? Anticoagulant (Coumadin, Plavix) Bisphosphonate 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 _____