REIDER FAMILY DENTISTRY

Medical History

Patient's Name: _____ Date: _____

Patient's DOB: _____

Have you ever had any of the following?

Please check all that apply

If you check "Yes" to any of the following, please explain in the space to the right.

Heart or Blood Pressure Problems

Heart condition (chest pain, heart attack, murmur, defect)	☐ Yes	☐ No	
Pacemaker or heart surgery	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
Prolonged bleeding	☐ Yes	☐ No	

Lung or Breathing Problems

Emphysema	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	

Digestive or Urinary Problems

Intestinal or stomach problems	☐ Yes	☐ No	
Stomach or colon cancer	☐ Yes	☐ No	
Liver disease or jaundice	☐ Yes	☐ No	
Kidney disease	☐ Yes	☐ No	

Brain or Nerve Problems

Stroke	☐ Yes	☐ No	
Epilepsy or seizures	☐ Yes	☐ No	
Fainting or dizzy spells	☐ Yes	☐ No	
Major head injury or tumor	☐ Yes	☐ No	
Stress or emotional disorder	☐ Yes	☐ No	

Other Health Problems

Cancer, tumor, or growth	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
AIDS, ARC, or HIV positive	☐ Yes	☐ No	
Venereal disease, Herpes II	☐ Yes	☐ No	
Artificial joint placement	☐ Yes	☐ No	
Arthiritis	☐ Yes	☐ No	
Cortisone (steroid) therapy	☐ Yes	☐ No	
Glaucoma or other eye problems	☐ Yes	☐ No	
Diabetes or low blood sugar	☐ Yes	☐ No	
Alcoholism or drug addiction	☐ Yes	☐ No	
Physical or mental disability	☐ Yes	☐ No	
Latex allergy (rubber gloves)	☐ Yes	☐ No	

Other health problems not previously mentioned: _____

Please continue on back…

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Please answer the following:

Have you ever had surgery or been hospitalized? ☐ Yes ☐ No _____

If yes, explain: _____

In the past 2 years, have you been under the care of a physician for something other than a checkup? ☐ Yes ☐ No _____

Have you ever had an allergic reaction or ill effect from any medicine? ☐ Yes ☐ No _____

Are you allergic or sensitive to any metals? (such as jewelry, snaps, etc.) ☐ Yes ☐ No _____

Are you currently taking medication or drugs of any kind (including non-prescription)? ☐ Yes ☐ No _____

If yes, please list: _____

If female:

Are you, or do you think you might be, pregnant? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Your medical doctor's name: _____ Location: _____

_____ _____

Patient's Signature *Date*

_____ _____

Dentist's Signature *Date*

Please do not write below this line

Office Use Only - updates

Date:				
Surgery:				
Hospitalization:				
Allergies:				
Medications:				
Initials:				
BP / HR:				