Restorative & Aesthetic Dental Associates

Scott E. Burke, D.M.D., F.A.G.D.
Leighton R. Philbrick, D.M.D., F.A.G.D.
Thomas W. Corwin, D.D.S., F.A.G.D.

650 Brighton Avenue
Portland, Maine 04102
(207) 773 - 6331
care@radentalmaine.com

Name_____
Last, First, Middle

D.O.B_____

Emergency contact: _____ Phone: _____

Medications and systemic conditions often affect the health of the teeth and supporting structures, therefore, an accurate medical history is necessary for optimum safe treatment.

Please answer **YES or NO and Circle** all that apply to you:

YES	NO	
		Abnormal blood pressure: High / Low
		Stroke
		Rheumatic Fever
		Allergies _____
		GERD (Gastroesophageal reflux disease)
		Latex Sensitivity/Allergy
		Epinephrine Sensitivity
		Epilepsy/Seizures
		Emphysema, C.O.P.D., Asthma
		Smoke/Chew Tobacco
		Chronic Sinus Problems
		Alcohol/Chemical Dependency
		Ulcer/Colitis
		Eating Disorder: Treated /Untreated
		Cancer: Type _____When_____
		Radiation/Chemo-Therapy
		Thyroid Disorder: Treated /Untreated
		Artificial Joint (Replacement)
		Back Problems Upper/Lower
		Arthritis, Rheumatism
		Snoring
		Kidney Disease
		Pregnant (women only) Due Date _____

YES	NO	
		H.I.V Positive
		Immune Deficiency
		Tuberculosis
		Drug Reaction /Allergy _____ (local anesthesia, penicillin, codeine, etc.)
		Anemia
		Subject to prolonged bleeding
		Diabetes: Treated /Untreated
		Blood Disease
		Heart Disease: Type_____
		Pacemaker
		Mitral Valve Prolapse/Heart murmur
		Liver Disease
		Hepatitis: Type_____
		Jaundice
		Herpes
		Sexually Transmitted Disease
		Mental Disease: Type_____
		Hearing Impaired
		Glaucoma
		Sleep Apnea / CPAP
		Chronic Head Aches /Migraines
		Birth Control (antibiotics can affect this)

Is there anything else you think is important for us to know about your Medical History?

_____

Physician's Name: _____ Date of last Physical Exam: _____

Physician's address:_____ Office Phone _____

Current Medications**:** _____

_____

Vitamins and/or supplements: _____

Date: _____ Signature: _____