Restorative & Aesthetic Dental Associates

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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		YES	NO	
		Abnormal blood pressure: High / Low			H.I.V Positive
		Stroke			Immune Deficiency
		Rheumatic Fever			Tuberculosis
		Allergies _____			Drug Reaction /Allergy _____ (local anesthesia, penicillin, codeine, etc.)
		GERD (Gastroesophageal reflux disease)			
		Latex Sensitivity/Allergy			Anemia
		Epinephrine Sensitivity			Subject to prolonged bleeding
		Epilepsy/Seizures			Diabetes: Treated /Untreated
		Emphysema, C.O.P.D., Asthma			Blood Disease
		Smoke/Chew Tobacco			Heart Disease: Type_____
		Chronic Sinus Problems			Pacemaker
		Alcohol/Chemical Dependency			Mitral Valve Prolapse/Heart murmur
		Ulcer/Colitis			Liver Disease
		Eating Disorder: Treated /Untreated			Hepatitis: Type_____
		Cancer: Type _____When_____			Jaundice
		Radiation/Chemo-Therapy			Herpes
		Thyroid Disorder: Treated /Untreated			Sexually Transmitted Disease
		Artificial Joint (Replacement)			Mental Disease: Type_____
		Back Problems Upper/Lower			Hearing Impaired
		Arthritis, Rheumatism			Glaucoma
		Snoring			Sleep Apnea / CPAP
		Kidney Disease			Chronic Head Aches /Migraines
		Pregnant (women only) Due Date _____			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: _____