Railway Avenue Dental Medical History

Although dental personnel primarily treat the area in and around your mouth, it is also a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes	O No	If Yes _____
When was the last time you had a medical examination?	O Yes	O No	Date: _____
Are you presently receiving treatment for any illness?	O Yes	O No	If Yes _____
Have you ever been hospitalized or had a major operation?	O Yes	O No	If Yes _____
Have you ever had a serious head or neck injury?	O Yes	O No	If Yes _____
Do you have any heart or circulatory problems?	O Yes	O No	If Yes _____
Do you have a pacemaker?	O Yes	O No	If Yes _____
Have you ever had rheumatic fever? When?	O Yes	O No	If Yes _____
Are you taking any medications, pills or drugs? If Yes, please specify the drug, dosage (if known) and reason for taking it.	O Yes	O No	If Yes _____ _____
Do you take, or have you taken Phen-fen or Redux?	O Yes	O No	If Yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes	O No	
Are you on a special diet?	O Yes	O No	
Do you smoke, vape, or use chewing tobacco? How much per day? How much per week?	O Yes	O No	Per day _____ Per Week_____
Do you use controlled substances?	O Yes	O No	
Have you ever been advised to take antibiotic pre-medication prior to dental treatment?	O Yes	O No	
Do you have food or seasonal allergies? Please specify.	O Yes	O No	_____

Female Patients, are you:

O Pregnant? O Breastfeeding/Nursing O Taking oral contraceptives?

Do you have any allergies to the following?

O Aspirin O Acrylic O Codeine O Latex
O Local Anesthetic O Metal O Penicillin O Sulfa Drugs
O Other: _____

Do you have, or have you had, any of the following?

- O Acid Reflux/Gerd
- O AIDS/HIV
- O Alcohol or chemical dependency
- O Anemia
- O Angina
- O Arthritis/Gout or Rheumatism
- O Artificial Joints or Valves
- O Asthma
- O Alzheimer's Disease
- O Blood Transfusion
- O Blood Disease
- O Breathing Problems
- O Bruise easily
- O Cancer
- O Chemotherapy
- O Chest Pain
- O Cold Sores/Fever Blisters
- O Congenital Heart Disorder
- O Convulsions
- O Cortisone Medication
- O Diabetes
- O Drug Addition
- O Eating Disorders
- O Easily Winded
- O Emphysema
- O Epilepsy/Seizures
- O Excessive Bleeding
- O Excessive Thirst
- O Fainting/Dizzy Spells
- O Frequent Cough
- O Frequent Diarrhea
- O Frequent Headaches
- O Genital Herpes
- O Glaucoma
- O HayFever
- O Heart Attack/Failure
- O Heart Murmur
- O Heart Trouble/Disease
- O Hemophilia
- O Hepatitis A
- O Hepatitis B or C
- O High Cholesterol
- O High Blood Pressure
- O Hives or Rash
- O Hyper/Hypoglycemia
- O Irregular Heartbeat
- O Kidney Disease
- O Leukemia
- O Liver Disease (Hepatitis/ Jaundice)
- O Low Blood Pressure
- O Lung Disease/Chest Pains
- O Mental or Nervous Disorder
- O Mitral Valve Prolapse
- O Multiple Sclerosis
- O Osteoporosis
- O Pain in Jaw Joints (TMD)
- O Parathyroid Disease
- O Psychiatric Care
- O Radiation Treatments
- O Recent Weight Loss
- O Renal Dialysis
- O Scarlet Fever
- O Shingles
- O Sickle Cell Disease
- O Sinus Trouble
- O Spina Bifida
- O Stomach Ulcers
- O Stomach/Intestinal Disease
- O Stroke
- O Swelling of Limbs (Lymphedema)
- O Thyroid Disease
- O Tonsilitis
- O Tuberculosis
- O Tumors or Growths
- O Ulcers
- O Venereal/Communicable Disease
- O Yellow Jaundice

Do you have any serious illness/disorder or allergy not previously listed? If yes, please provide additional details.

_____

_____

Do you grind or clench your teeth?	O Yes	O No
Do you suffer from any of the following:		
Headaches?	O Yes	O No
Earaches?	O Yes	O No
Neck aches?	O Yes	O No
Sore/tender facial muscles?	O Yes	O No

Is there any additional information related to your health that has not been addressed previously?

_____

_____

_____

I, the undersigned, have completed the above questionnaire and/or update and I confirm that it is accurate to the best of my knowledge.
I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Parent or Guardian: _____ Date: _____

Patient Name: _____ Date of Birth: _____