Ravenna Family Dentistry
Adult Dental Health History
(Confidential)

Today's Date _____

Patient's Name: Last_____First_____MI_____Birthday_____

DENTAL HISTORY

Reason for today's visit_____
Former dentist (if applicable)_____Location_____
Date of last dental care_____ Date of last dental x-rays_____
Are you in any discomfort at this time?_____ What are you taking for the discomfort, if anything? _____

MEDICAL HISTORY

Physician's Name_____ Date of last visit_____
Address_____ Phone # _____
(Women) Are you pregnant? _____ Nursing _____ Using birth control? _____

Check if you have or have had any of the following:

__Artificial Heart Valve(s)	__Asthma	__Kidney Disease	__Hemophilia
__Artificial Joint(s)	__COPD	__Diabetes	__Tobacco Use
__Previous Infective Endocarditis	__Cancer	__Stroke	__Drug dependency
	__Chemotherapy	__Thyroid Problems	__Nervous problems
__High blood pressure	__Radiation Therapy	__Frequent headaches	__Psychiatric Care
__Low blood pressure	__Rheumatoid Arthritis	__Jaw Pain	__STD/Venereal disease
__Fainting	__Epilepsy	__Take 1 aspirin daily	__Alcoholism
__Dry Mouth	__Liver Disease	__Ulcers	__Autoimmune disease
__Tuberculosis	__Hepatitis	__HIV positive/AIDS	__Osteoporosis
__Shortness of breath	__Cortisone/Steroid Treatment	__Anemia	medications
__ Pacemaker		__Blood Disease	__Spleen removal

__Other heart problems/congenital heart disease

MEDICATIONS

Has your physician or surgeon requested you premedicate (take antibiotics) before dental treatment? _____
List the medications you are currently taking, along with the dosages and frequencies and reasons for taking them:
_____
_____
_____
Preferred Pharmacy_____ Phone #_____

ALLERGIES

Do you have any of the following allergies?

__Aspirin	__Codeine	__Penicillin	__Anxiety medications (ex: Valium)	
__Local anesthetics	__Sulfa	__Sulfa	__Ibuprofen/NSAID	__Jewelry or other metals

__Other, please list_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge and is only for use in the treatment, billing, and processing of insurance for which I am entitled. I will not hold my dentist or any member of the staff responsible for errors or omissions that I may have made in the completion of this form

Date_____Signature_____

MEDICAL HISTORY UPDATE

Has there been any changes in your health since your last dental appointment?_____ Yes _____ No
For what conditions? ____
Do you have any changes in your medications? _____ If so, please list ____
Do you have any new allergies? ____ If so, to what? ____

Date ______________ Signature ____

Has there been any changes in your health since your last dental appointment?_____ Yes _____ No
For what conditions? ____
Do you have any changes in your medications? _____ If so, please list ____
Do you have any new allergies? ____ If so, to what? ____

Date ______________ Signature ____

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