Richardson DMD, Inc.

Patient Health History

Patient Name: _____ **Date of Birth:** _____ **Gender:** _____

When was your last dental visit? _____ **Name and phone number of previous office:**_____
Name of your most recent medical office and your primary physician: _____
Reason and approximate date of your last Emergency Room visit: _____

DO YOU HAVE or HAVE YOU EVER HAD:	Y / N		DO YOU HAVE or HAVE YOU EVER HAD:	Y / N	
Heart disease	☐	☐	Tuberculosis	☐	☐
Damaged heart valve	☐	☐	Sexually transmitted disease	☐	☐
Heart Murmur	☐	☐	Hepatitis (Type)	☐	☐
High or low blood pressure	☐	☐	HIV/AIDS	☐	☐
Pacemaker or implantable defibrillator	☐	☐	Tumor, abnormal growth	☐	☐
Artificial heart valve	☐	☐	Cancer	☐	☐
Joint replacement	☐	☐	Radiation Therapy	☐	☐
Blood thinners	☐	☐	Chemotherapy	☐	☐
Stroke	☐	☐	Methadone use	☐	☐
Anemia or other blood disorder	☐	☐	Emphysema	☐	☐
Prolonged bleeding due to a slight cut (INR>3.5)	☐	☐	Cold Sores	☐	☐
Sinus trouble	☐	☐	Persistent swollen glands	☐	☐
Kidney disease	☐	☐	History of Infections	☐	☐
Liver disease	☐	☐	Alcohol-how many per week	☐	☐
Thyroid problems	☐	☐	Recreational Drugs	☐	☐
Systemic Lupus	☐	☐	**DO YOU NEED:**		
Asthma	☐	☐	Anxiety medication prior to dental appointments?	☐	☐
Rheumatic or Scarlet Fever	☐	☐	Antibiotics prior to dental appointments?	☐	☐
Diabetes	☐	☐	For what reason?		
Glaucoma	☐	☐	**ARE YOU:**		
Epilepsy/Seizures	☐	☐	Aware of a change in your health in the last 24 hours (i.e fever, chills, new cough, etc.)	☐	☐
Neurological Disorders (ADD/ADHD, etc.)	☐	☐			
Mental Health Issues	☐	☐	A smoker, smoked previously, use smokeless tobacco	☐	☐
Paget's Disease	☐	☐	FEMALE – taking birth control pills	☐	☐
Osteoporosis/Osteopenia	☐	☐	FEMALE – Pregnant or nursing (# of weeks_____)	☐	☐
Bisphosphonate Medications: Ibandronate(Boniva), Alendronate(Fosamax), Risedronate(Actonel), etc.	☐	☐	**Allergies:** _____	☐	☐

List all medications, supplements, and/or vitamins

Medication/Supplement	Purpose	Medication/Supplement	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pharmacy: _____ **May we contact them for your medication list?** _____

I certify that I have answered the questions on this form to the best of my knowledge. I understand that providing incorrect information can be dangerous to the health of myself, or the patient listed above. I will inform the dental office of any changes in my medical status.

Patient or legal guardian signature _____ **Today's Date:** _____