TENNESSEE RIVER DENTAL

Medical History

Have you ever had any of the following?

Cardiovascular	Yes	No
Angina	☐	☐
Artificial Heart Valve	☐	☐
Atrial Fibrillation	☐	☐
Congenital Heart Defect	☐	☐
Repaired?	☐	☐
Residual Defect?	☐	☐
Congestive Heart Failure	☐	☐
Heart Attack	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Irregular Heartbeat	☐	☐
Pacemaker	☐	☐
Other cardiovascular issues _____		
Hematologic		
Abnormal bleeding/bruising	☐	☐
Anemia	☐	☐
Blood Disease	☐	☐
Blood Thinners	☐	☐
Hemophilia	☐	☐
Infective Endocarditis	☐	☐
Sickle Cell Disease	☐	☐
Transfusion	☐	☐
Other hematologic issues_____		
Pulmonary		
Asthma	☐	☐
COPD	☐	☐
Difficulty Breathing	☐	☐
Lung Disease	☐	☐
Sinus Problems	☐	☐
Sleep Apnea	☐	☐
CPAP?	☐	☐
Tuberculosis	☐	☐
Other pulmonary issues_____		
Gastrointestinal		
Acid Reflux/GERD	☐	☐
Ulcers	☐	☐
Other GI issues_____		
Musculoskeletal		
Artificial Joints	☐	☐
Head Injuries	☐	☐
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Rheumatoid Arthritis	☐	☐
Other musculoskeletal issues _____		

Neurological	Yes	No
Depression	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐
Nervous Disorders	☐	☐
Psychiatric Care	☐	☐
Stroke	☐	☐
Other neurologic issues_____		
Endocrine		
Diabetes	☐	☐
Thyroid Disorder	☐	☐
Parathyroid Disorder	☐	☐
Other endocrine issues_____		
Hepatic		
Hepatitis	☐	☐
Type: _____		
Liver Disease	☐	☐
Other liver issues_____		
Renal		
Dialysis	☐	☐
Kidney Disease	☐	☐
End Stage Renal Failure	☐	☐
Other kidney issues_____		
Immune		
Autoimmune Disease	☐	☐
Cancer	☐	☐
Where?_____		
How treated?_____		
Chemotherapy	☐	☐
Cold sores/fever blisters	☐	☐
HIV/AIDS	☐	☐
Lupus	☐	☐
Radiation Treatment	☐	☐
Rheumatic Fever	☐	☐
Sjogren's Syndrome	☐	☐
Transplant	☐	☐
Which organ?_____		
When?_____		
Other immune issues_____		
Reproductive		
Sexually Transmitted Disease	☐	☐
Pregnancy/Nursing	☐	☐
Other reproductive issue_____		

Please list all surgeries you have had in the past:

Date	Surgery	Complications?

Please list all medications/herbal supplements/vitamins you currently take:

Medication	Dosage	When taken	Reason for taking

Are you currently being managed on a pain contract? Yes ☐ No ☐

Have you ever been treated with bisphosphonate medications? Yes ☐ No ☐

Are you allergic to any of the following?

	Yes	No
Acrylic	☐	☐
Cephalosporins	☐	☐
Clindamycin	☐	☐
Codeine	☐	☐
Dental Anesthetic	☐	☐
Which one/class?_____		
Latex	☐	☐
Macrolides	☐	☐

	Yes	No
Metals	☐	☐
Which one?_____		
NSAIDs	☐	☐
Opioids	☐	☐
Penicillin	☐	☐
Sulfa	☐	☐
Other:_____		

Do you use any of the following?

Cigarettes ☐ ☐
Packs per day: _____
Years used: _____
Chewing tobacco
Cans per day:_____
Years used:_____

Alcohol ☐ ☐
Drinks per day:_____
History of abuse? Yes ☐ No ☐
Recreational drugs
Which one(s)?_____
Years used:_____
Date last used:_____

Physician Information:
Name: _____
Specialty:_____
Phone #:_____
Address:_____
_____
Date last seen:_____

Patient Signature:_____
Date:_____