ROBISON DENTAL CARE
MEDICAL HISTORY

Patient name:_____

What is you medical doctor's name_____Phone_____

1. Have you had any medical care in the past 2 years?..... Yes No
   Describe_____
2. In the past 2 years have you taken any medicines or drugs?..... Yes No
   If yes, list name & dosage_____
3. Are you taking any medications, drugs,herbal remedies or regular doses of aspirin?..... Yes No
   If yes, list name & dosage_____
4. Have you ever taken bone loss prevention drugs?(Fosamax,Actonel,Boniva,bisphosphonates) Yes No
   If yes, list name & dosage_____
5. Do you have or have you had an allergic or adverse reaction to any substance or medication? Yes No
   If yes, specify_____
6. Have you been a patient in the hospital during the past 5 years?..... Yes No

7. Indicate which of the following you have had, or have at present. Circle "Yes" or "No"

Heart(surgery,disease,attack)	Yes No	Ulcers	Yes No	Hepatitis A B C	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal disease	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S./H.I.V.Positive	Yes No
Artificial Heart Valve	Yes No	Glaucoma	Yes No	ColdSores/FeverBlisters	Yes No
Heart murmur	Yes No	Contact Lenses	Yes No	Blood Transfusion	Yes No
High/Low Blood Pressure	Yes No	Emphysema	Yes No	Hemophilia	Yes No
Mitral Valve Prolapse	Yes No	Chronic Cough	Yes No	Sickle Cell disease	Yes No
Rheumatic Fever	Yes No	Tuberulosis	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Asthma	Yes No	LiverDisease/Jaundice	Yes No
Cortisone Medicine	Yes No	HayFever/allergy	Yes No	Neurological Disorder	Yes No
Swollen ankles	Yes No	Latex sensitivity	Yes No	Epilepsy or Seizures	Yes No
Stroke	Yes No	Sinus Trouble	Yes No	Fainting or DizzySpells	Yes No
Diet(special/restricted)	Yes No	Radiation Therapy	Yes No	Nervous/ Anxious	Yes No
Artificial Joints(hip,knee,etc)	Yes No	Chemotherapy	Yes No	Psychiatric Care	Yes No
Kidney Trouble	Yes No	Tumors	Yes No	Cancer	Yes No

8. Have you lost or gained more than 10 pounds in the past year?..... Yes No
9. Do you have or have you had any disease, condition or problem not listed?..... Yes No
10. Women:Are you pregnant or think you could be pregnant Yes __months No Nursing? Yes No
11. Do you use birth control prescriptions?..... Yes No

I understand the above information is necessary to provider me with dental care in a safe manner. I have answered all questions to the best of my knowledge. Should any further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian signature_____Date_____