RIVER RIDGE
DENTAL CARE

HEALTH HISTORY

(PLEASE PRINT)

PERSONAL PHYSICIAN _____

STREET

_____

CITY STATE ZIP

YES NO

☐ ☐ HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION?

DATE/REASON _____

☐ ☐ ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN?

REASON _____ PHYSICIANS NAME _____

☐ ☐ HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING:

☐ ASPIRIN ☐ PENICILLIN ☐ CODEINE ☐ ACRYLIC ☐ METAL ☐ LATEX ☐ SULFA DRUGS ☐ LOCAL ANESTHETICS

☐ OTHER _____

☐ ☐ HAVE YOU EVER TAKEN AN ORAL OR IV FORM OF BISPHOSPHONATE MEDICATION SUCH AS FOSAMAX, BONIVA, ACTONEL, ZOMETA, XGEVA, PROLIA, ETC.?

☐ ☐ DO YOU BLEED EXCESSIVELY UPON INJURY?

☐ ☐ DO YOU SMOKE OR USE SMOKELESS TOBACCO? IF YES, FREQUENCY _____

☐ ☐ WOMEN: ARE YOU... ☐ PREGNANT ☐ NURSING ☐ TAKING ORAL CONTRACEPTIVES

CHECK ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD

☐ AIDS/HIV POSITIVE
☐ ANXIETY
☐ ARTHRITIS
☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL JOINT
☐ ASTHMA
☐ CANCER
_____
_____

☐ DIABETES
☐ DRUG ADDICTION
☐ EPILEPSY/SEIZURES
☐ HEART MURMUR
☐ HEART PROBLEMS
_____
_____
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE

☐ JAUNDICE
☐ KIDNEY PROBLEMS
☐ LOW BLOOD PRESSURE
☐ LUNG PROBLEMS
☐ MENTAL ILLNESS/DISORDER
☐ OSTEOPOROSIS OR OTHER BONE CONDITION
☐ RHEUMATIC FEVER
☐ SEXUALLY TRANSMITTED DISEASE

☐ SINUS PROBLEMS
☐ SLEEP APNEA/CPAP
☐ SNORING PROBLEMS
☐ STOMACH/INTESTINAL DISEASE
☐ STROKE
☐ TUBERCULOSIS
☐ OTHER
_____
_____

UPDATED

INITIAL / DATE	INITIAL / DATE	INITIAL / DATE

I WILL NOTIFY THE DENTIST OF ANY CHANGE IN MY HEALTH HISTORY PRIOR TO MY DENTAL TREATMENT. I CERTIFY THE ABOVE INFORMATION TO BE CORRECT.

_____ _____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF MINOR) DATE

SEE PAGE 2 FOR LIST OF MEDICATIONS

RIVER RIDGE
DENTAL CARE

(PLEASE PRINT)

MEDICATIONS

NAME	DOSAGE	REASON

UPDATED

INITIAL / DATE	INITIAL / DATE	INITIAL / DATE

PERSON TO BE CONTACTED IN AN EMERGENCY (OTHER THAN HOUSEHOLD MEMBER)

NAME ADDRESS PHONE