Time 12:48 PM

S. Rangrass D.D.S., P.C.

Date 1/8/2018

ADULT MEDICAL HISTORY FORM-1-8-18*COPY #7

Patient Name: Birth Date: Date Created:

Please answer each question by marking either yes or no.

Do you or have you had any of the following?

Anxiety/Nervousness	◯ Yes ◯ No	Addiction to Drugs	◯ Yes ◯ No	Aids/HIV Positive	◯ Yes ◯ No
Alcoholism	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Arthritis	◯ Yes ◯ No
Artificial Joints or Bones	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Bells Palsy/Shingles	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Cancer/Chemotherapy	◯ Yes ◯ No	Chronic Cough	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Epilepsy/Seizures/Fainting Spells	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Heart Trouble/Chest Pain	◯ Yes ◯ No	Hemophilia/Abnormal Bleeding	◯ Yes ◯ No
Hepatitis	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No
Growths or Tumors	◯ Yes ◯ No	Jaundice	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Major Operation in the Last 5 years	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Pace Maker	◯ Yes ◯ No	Psychiatric/Psychological Care	◯ Yes ◯ No
Prolonged Bleeding from Slight cut or Su	◯ Yes ◯ No	Radiation Therapy	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Venereal Disease	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	GI Reflux	◯ Yes ◯ No
Cold Sores	◯ Yes ◯ No				

Do you smoke/chew Tobacco? If yes how long? ◯ Yes ◯ No If yes

Do you have any medical condition or disease not listed above? ◯ Yes ◯ No If yes

Have you ever taken prescription drugs/herbal remedies for weight loss? ◯ Yes ◯ No If yes

Have you gained/lost more than 10 Lbs in the last year? ◯ Yes ◯ No

Are you allergic to any of the following drugs?

Aspirin	◯ Yes ◯ No	Codeine	◯ Yes ◯ No	Latex	◯ Yes ◯ No
Local Anesthetics	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No	Sulfa Drugs	◯ Yes ◯ No
Other Antibiotics	◯ Yes ◯ No	Any other drugs	◯ Yes ◯ No		

Are you aware of having an allergic (or adverse) reaction to any medication or substance? ◯ Yes ◯ No If yes

Are you currently taking any medications(including supplements)? ◯ Yes ◯ No If yes

Are you being treated or medicated for anything? ◯ Yes ◯ No If yes

Are you currently taking Asprin/Blood Thinners? ◯ Yes ◯ No

Is there any other condition you think might affect dental treatment? ◯ Yes ◯ No If yes

Physicians Name/Date of last visit Comment

Women: Are you Pregnant or think you might be pregnant? ◯ Yes ◯ No

If yes: How many months Comment

Nursing? ◯ Yes ◯ No

Do you use birth control? ◯ Yes ◯ No

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

Signature of Patient, Parent or Guardian:

X Date:_____

Clinical Notes Only