RVSC - Medical History Update

Patient Name _____ Date of birth _____ Phone _____
Address _____ Email _____
Employer _____ Dental Insurance _____
Name of Medical Doctor _____ Last Medical Visit _____
Emergency Contact Person _____ Phone _____

How would you estimate your health? ____Excellent ____Good ____Fair ____Poor

Allergic Reactions *to any of the following*: **Please Circle**

Aspirin Ibuprofen Acetaminophen (Tylenol) Codeine Penicillin Erythromycin Epinephrine
Tetracycline Sulfa Local anesthetic Latex Fluoride Metals (nickel, gold, silver)
Food allergy: _____ Any Others: _____

Has your Medical Doctor recommended a **pre-medication** prior to dental visits? _____ YES _____ NO

Medical conditions you have, or have had in the past: **Please Circle**

Heart Problems / Pacemaker
High BP / Low BP
Infective Endocarditis / Stent
Artificial Heart Valve / Natural Heart Valve

Blood Thinners / Bleeds easily
High Cholesterol

Vision / Glaucoma / Blindness
Hearing Loss / Deafness

Diabetes (Type 1 or Type 2)

Exhausted or Fatigued
Asthma / Oxygen Assisted
Shortness of Breath
Emphysema / COPD / TB

Cancer / Tumor / Abnormal Growth
Chemotherapy / Radiation

Wheelchair Dependent
Artificial Joints
Osteoporosis / Bisphosphonates

Rheumatic Fever / Scarlet Fever
Rheumatoid Arthritis
Autoimmune Disorder / Lupus
MS / Crohn's / UC
Arthritis / Fibromyalgia

Liver Disorder / Jaundice
Kidney Disorder / Dialysis
Thyroid Disorder
Anemia / Blood Disorder

Hepatitis
STD / HIV / AIDS
Hives / Skin Rash
Chicken Pox / Shingles / Measles
Cold Sores / Viral Infection
Lumps or Swelling (mouth)

Gastric Reflux / Ulcers
Digestive Disorder / IBS
Prostate Disorder / Colon

COVID 19 / COVID Vaccine

Neurological Disorder
Stroke / Seizures / Epilepsy
Dementia / Alzheimer's / Memory Loss
Autism / Parkinson's / MS

Anxiety / Panic Attacks / **Dental Anxiety**
ADD / ADHD / PTSD / Bipolar
Psychiatric Treatment / Mental Illness
Unhappy / Depressed / Emotional
Antidepressants

Pain Management / Chronic Pain
Frequent Headaches / Migraines

Smokes / Smokeless Tobacco / Vape
Alcohol / Recreational Drugs
Medical Marijuana / Cannabis / CBD

Pregnant at This Time. *Due Date:* _____
Birth Control Medication
Weight Management Medication

Head or Neck Injury
Facial Injuries / Jaw Surgeries
Back Injury / Back Surgeries

Any sleeping problems: Please Circle

Clenching Sleep Apnea Jaw Soreness CPAP RLS
Grinding Insomnia Snoring Snore Appliance

Any illness/condition not listed above: _____

Hospitalized or had any recent surgeries? _____

Please list all Medications you take: (include *prescriptions, vitamins, and/or supplements)*

Drug Name: / Purpose of medication:	Drug Name: / Purpose of medication:
_____/_____	_____/_____
_____/_____	_____/_____
_____/_____	_____/_____
_____/_____	_____/_____

Pharmacy Name: _____ Phone # _____

Patient's Signature: _____ Date: _____