RURAL HEALTH, Inc.
We specialize in you

Dental/Medical History

Patient Name:_____Date of Birth:_____

Why are you here today?_____

Are you having pain or discomfort at this time? _____ □ Yes □ No

If yes, what type and where? _____

Have you been under the care of a medical doctor during the past two years? □ Yes □ No

Medical Doctor's Name: _____

Address: _____

Telephone Number: _____

Are you taking any medication, drugs, or pills? □ Yes □ No

If yes, please list:_____

Are you taking any prescription blood thinners (Coumadin, Warfarin, Plavix, etc.)? □ Yes □ No

If yes, please list: _____

Are you taking or have you ever taken any prescription weight loss drugs, such as Fen-Phen, etc.?
□ Yes □ No

If yes, please list:_____

Are you taking or have you ever taken any prescription medications for an osteoporosis condition (or preventative for this condition) such as the bisphosonates Fosamax or Boniva, or any others?
□ Yes □ No

If yes, please list: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance?
□ Yes □ No

If yes, please list:_____

Have you ever been diagnosed with or had Lupus or any other autoimmune type diseases? □ Yes □ No

If yes, please list: _____

Do you use two or more pillows to sleep? □ Yes □ No

Do you use tobacco products (smoke or chew tobacco)? □ Yes □ No

Do you drink alcoholic beverages? □ Yes □ No

Are you pregnant? □ Does not apply □ Yes □ No

If yes, when are you due? _____

Are you nursing? □ Does not apply □ Yes □ No

Are you taking birth control pills? □ Does not apply □ Yes □ No

Have you ever had (mark yes or no)?

Heart Disease or Attack	□ Yes	□ No	Artificial Joints (Hip, Knee, Etc.)	□ Yes	□ No	Dental Phobia	□ Yes	□ No
Heart Failure	□ Yes	□ No	Stroke	□ Yes	□ No	Arteriosclerosis	□ Yes	□ No
Angina Pectoris	□ Yes	□ No	Venereal Disease	□ Yes	□ No	Ulcers	□ Yes	□ No
Congenital Heart Disease	□ Yes	□ No	Heart Murmur	□ Yes	□ No	AIDS	□ Yes	□ No
Cancer	□ Yes	□ No	Glaucoma	□ Yes	□ No	Blood Transfusion	□ Yes	□ No
Diabetes	□ Yes	□ No	Cortisone Medication	□ Yes	□ No	Cold Sores/Fever Blisters/Herpes	□ Yes	□ No
HIV Positive	□ Yes	□ No	Hay Fever	□ Yes	□ No	Artificial Heart Valve	□ Yes	□ No
High Blood Pressure	□ Yes	□ No	Anemia	□ Yes	□ No	Heart Pacemaker	□ Yes	□ No
Mitral Valve Prolapse	□ Yes	□ No	Heart Surgery	□ Yes	□ No	Memory Loss	□ Yes	□ No
Emphysema	□ Yes	□ No	Hepatitis B (serum)	□ Yes	□ No	Asthma	□ Yes	□ No
Chronic Cough	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No	Blood Thinners	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Epilepsy or Seizures	□ Yes	□ No	Fainting or Dizzy Spells	□ Yes	□ No
Liver Disease	□ Yes	□ No	Pain in Jaw Joints	□ Yes	□ No	Chemotherapy	□ Yes	□ No
Arthritis	□ Yes	□ No	Radiation Therapy	□ Yes	□ No	Drug Addiction	□ Yes	□ No
Allergies or Hives	□ Yes	□ No	Thyroid Problems	□ Yes	□ No	Alcohol Abuse	□ Yes	□ No
Sinus Trouble	□ Yes	□ No	Hepatitis C	□ Yes	□ No	Psychiatric Treatment	□ Yes	□ No
Surgeries (Please List type and When):								

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient or Guardian Signature: _____

Date: _____