Rumford Dental, Inc.

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Health • Function • Beauty

Medical History

Patient Name:

Date of Birth:

Please Circle the Appropriate Answer

Yes No Is your general health good?
Yes No Have you been hospitalized in the last three years?
Yes No Do you have a primary care physician? If so, who?
Yes No Have you had problems with prior dental treatment?
Yes No Do you have dental pain now?
Yes No Have you had recent dental x-rays? Date of last Dental exam:
Yes No Are you currently taking any Medications? please list:

Yes No Do you have any Allergies? please circle or list:
penicillin codeine sulfa drugs iodine metals latex gluten

Have you recently experienced:

Yes	No	chest pain	Yes	No	stomach problems, ulcers
Yes	No	shortness of breath	Yes	No	oral ulcers
Yes	No	dizziness or fainting	Yes	No	dry mouth
Yes	No	ringing in the ears	Yes	No	difficulty swallowing
Yes	No	headaches	Yes	No	chronic nasal congestion
Yes	No	vision changes	Yes	No	sleep disturbances
Yes	No	seizures	Yes	No	TMJ jaw pain

Have you been diagnosed with:

Yes	No	Heart disease	Yes	No	Tumor or cancer
Yes	No	Cerebrovascular disease	Yes	No	Skin disease
Yes	No	Hepatitis or liver disease	Yes	No	Anemia or blood-related disease
Yes	No	Kidney or bladder disease	Yes	No	Diabetes
Yes	No	Skeletal disease or osteoporosis	Yes	No	Thyroid or endocrine disease
Yes	No	Arthritis	Yes	No	Sleep Apnea

Do you have or have you had:

Yes	No	artificial joint placement	Yes	No	chemotherapy
Yes	No	prosthetic heart valve	Yes	No	radiation treatment
Yes	No	organ transplant	Yes	No	osteoporosis medication
Yes	No	pacemaker	Yes	No	hospitalization or surgery

as applicable:

Yes No Are you pregnant or nursing? Yes No Do you take birth control medication?

please list any additional issues not covered by this form:

Patient Signature: Date:

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health or medication.