

Ravi Doctor DDS



Medical History

Patient name: _____

Date: _____

Although our dental team primarily treats the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physicians care now? Yes No Name & phone # of Dr. _____
- Have you ever been hospitalized or had a major operation Yes No Why? Date? _____
- Have you ever had a serious head or neck injury? Yes No What? Date? _____
- Are you taking herbal supplements, pills, medications, or drugs Yes No ~ If yes, fill out back of this sheet.
- Do you take, or have you taken, Phen-Fen or Redux? Yes No For how long? _____ List dates: _____
- Do you take or have you taken Bisphosphonates for osteoporosis? Yes No What/When? _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No What? How much? _____
- Do you use controlled substances / street drugs (marijuana, cocaine, etc) Yes No

Are you allergic to *any* of the following?

- Aspirin Penicillin Antibiotics Codeine Local Anesthesia Latex
- Metals Sulfa Drugs Food Allergies Barbituates/Sedatives Acrylic
- other _____ Describe your reactions: _____

Do you have, or have you ever had, any of the following: (* indicates condition may require medication prior to dental treatment)

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spinal Bifida |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve P rolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease* | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives / Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Osteoporosis | | | |

Have you had any illness not listed above? Yes No Describe: _____

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Are you interested in or concerned about:

Orthodontics to straighten your teeth..... Yes No Bad breath: causes and ways to control it..... Yes No
 Cosmetic Dentistry to improve your smile..... Yes No Bleaching / Whitening your teeth..... Yes No

Please mark the following medications you are currently taking:

Cardiovascular Medication

- Antiplatelet:
 - Aspirin
 - Plavix
 - Other _____
- Anticoagulant:
 - Coumadin (Warfarin)
 - Other _____
- Beta Blocker:
 - NonSelective:
 - Inderal (Propandol)
 - Corgard (Nadolol)
 - Other _____
 - Selective
 - Lopressor (Metoprolol)
 - Tenormin (Atenolol)
 - Other _____
- Calcium Channel Blocker:
 - Calan (Verapamil)
 - Procardia XL (Nifedipine)
 - Other _____
- Nitro Glycerin
- Lipid Lowering Agent:
 - Lipitor (Atorvastatin)
 - Zocor (Simvastatin)
 - Other _____

Cardiovascular Medication (continued)

- Anti Arrhythmecs (Inotropics)
 - Lanoxin (Digoxin)
 - Crystodigin (Digitoxin)
 - Other _____
- Diuretics:
 - Lasix (Furosemide)
 - Midamore (Chlorothiazine)
 - Other _____
- Ace Inhibitor:
 - Zestril (Lisinopril)
 - Accupril (Quinapril)
 - Monopril (Fosinopril)
 - Other _____

Diabetic Medication:

- Insulin
- Diabeth
- Glucotrol
- Glucophage
- Other _____

Thyroid Medication:

- Synthroid
- Other _____

Respiratory Medication

- Bronchdilators:
 - Proventil
 - Ventolin (Albuterol)
 - Atrovent (Pratropium)
 - Serevent (Salmeterol Xinofoate)
 - Theodur (Theophylline)
 - Other _____
- Steroids:
 - Flovent
 - Vancer
 - Aerobid
 - Other _____
- Combination:
 - Combivent
 - Advare
 - Other _____

Bisphosphonate Drugs:

- Fosomax
- Bondrona
- Actone
- Zometa
- Other _____

List medications/supplements you are taking that are not listed above:

Name of Medication	Why needed	Amount taking	How long	Dr, Prescribing
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FOR WOMEN ONLY:

If you are using oral contraceptives, it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives; therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed. Please consult with your physician for further guidance. We use Nitrous Oxide (laughing gas/relaxing gas) and, if pregnant, it can be harmful to your baby. It is important that if nitrous oxide or antibiotics are being used, that you notify us if you are pregnant!

Are you currently: Pregnant / might be pregnant Nursing Taking Oral Contraceptives
 Trying or planning to become pregnant in the near future Not pregnant at this time

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or to the patient's) health. It is my responsibility to inform the dental office , prior to treatment, of any changes in medical status in the future.

 Signature of patient or guardian Date Relationship to patient Doctor Initials