RG Dental Group
of Richboro

56 Newtown Richboro Rd.
Richboro, PA 18954
215-355-6406

MEDICAL HISTORY

Patient name: _____ **Birth date**: _____

Please list any medications, pills, or drugs you are currently taking:

_____ _____
_____ _____
_____ _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Have you ever taken medication for osteoporosis (bisphosphonates)? Yes No

Do you use tobacco? Yes No **Do you use controlled substances?** Yes No

Are you allergic to any of the following? Circle if yes.

Aspirin	Local Anesthetics	Latex (rubber)	Other:
Penicillin	Acrylic	Sulfa Drugs	_____
Codeine	Metal		_____

Do you have/had any of the following? Circle if yes.

AIDS/HIV Positive	Convulsions	Heart Pacemaker	Recent Weight Loss/ Gain
Alzheimer's Disease	Cortisone Medicine	Heart Disease	Renal Dialysis
Anaphylaxis	Dementia	Hemophilia	Rheumatic Fever
Anemia	Diabetes	Hepatitis A, B, or C	Rheumatism
Angina	Drug Addiction	High Blood Pressure	Scarlet Fever
Arthritis/Gout	Easily Winded	High Cholesterol	Shingles
Artificial Heart Valve	Edema	Hives or Rash	Sickle Cell Disease
Artificial Joint (Hip or	Emphysema	Hypoglycemia	Sinus Trouble
Knee replacement)	Epilepsy or Seizures	Kidney Problems	Spina Bifida
Arrhythmia	Excessive Bleeding	Leukemia	Stomach/Intestinal
Asthma	Excessive Thirst	Liver Disease	Disease
Blood Disease	Fainting Spells/Dizziness	Low Blood Pressure	Stroke
Blood Transfusion	Frequent Cough	Lung Disease	Thyroid Disease
Breathing Problem	Frequent Diarrhea	Mitral Valve Prolapse	Tonsillitis
Bruise Easily	Frequent Headaches	Organ Transplant	Tuberculosis
Cancer	Genital Herpes	Osteoporosis	Ulcers
Chemotherapy	Glaucoma	Pain in Jaw Joints	Venereal Disease
Chest Pains	Hay Fever	Parathyroid Disease	Yellow Jaundice
Cold Sores/Fever Blisters	Heart Attack/Failure	Psychiatric Care	
Congenital Heart Disorder	Heart Murmur	Radiation Treatments	

To the best of my knowledge, the information provided on this form is accurate. I understand that providing incorrect or the omission of information can be dangerous to my (or patient's) health. It is my responsibility to inform RG Dental Group Creek Dental of any changes in medical status.

Patient Signature: _____ **Date:** _____