Jacob J. Ridl D.D.S.

Patient Name _____ Nickname_____

Name of General Physician_____

Date of last physical examination _____ Purpose_____

MEDICAL HISTORY

YES	NO		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Lung Disease/COPD	☐	☐	Frequent headaches
☐	☐	Bone Density Medications	☐	☐	Chronic Sinus trouble	☐	☐	Cold sore/Herpes
☐	☐	Rheumatic fever	☐	☐	Tuberculosis	☐	☐	Blood disease
☐	☐	Rheumatic Heart disease	☐	☐	Asthma	☐	☐	Blood transfusion
☐	☐	Heart Murmur/MVP	☐	☐	Shortness of breath	☐	☐	Prolonged Bleeding INR____
☐	☐	Heart Valve Replacement	☐	☐	Hepatitis, Type ____	☐	☐	Epilepsy
☐	☐	Artificial Prosthesis	☐	☐	Liver Disease/Jaundice	☐	☐	Fainting Tendency
		ie: heart valve, joints	☐	☐	Cancer or Tumor	☐	☐	Glaucoma
☐	☐	High Blood Pressure	☐	☐	Diabetes, Type _____	☐	☐	Autoimmune disease
☐	☐	Arterial Stent			A1C _____	☐	☐	Organ Transplant
☐	☐	Heart Catheterization	☐	☐	Kidney disease	☐	☐	Chemotherapy
☐	☐	Stroke	☐	☐	Anemia	☐	☐	Mental disorders
☐	☐	Pacemaker	☐	☐	HIV/AIDS	☐	☐	Diverticulitis
☐	☐	Chest pain/Heart attack	☐	☐	Sexually Transmitted diseases	☐	☐	Thyroid disease
☐	☐	Internal Automatic Defibrillator						

Are you allergic to or suffer any ill effects from:

☐ Penicillin ☐ Codeine ☐ Dental Anesthetic
☐ Aspirin/NSAIDS ☐ Household Bleach ☐ Latex
☐ Sulfa Drugs ☐ Sulfites (i.e. red wine) ☐ Other _____

WOMEN ONLY: Are you pregnant? _____ How many months? _____ Are you breast feeding? _____

Has your physician recommended you to pre-medicate prior to dental appointments? _____
Prescription: _____
List any medications you are taking _____

Marijuana or substance abuse ❑ Yes ❑ No

Referred by _____ Last Dental Exam _____
Previous dentist _____
WHAT IS YOUR IMMEDIATE DENTAL CONCERN?_____

CHECK IF YOU HAVE, OR EVER HAD, THE FOLLOWING:

1. Unhappiness with appearance of your teeth. . . ❑
2. Unfavorable dental experiences. . . . . ❑
3. Preference for no dental anesthetic. . . . . ❑
4. Problems or bad reactions to dental anesthetic. . ❑
5. Orthodontic treatment (braces), when _____ . . . . ❑
6. Periodontal (gum) treatment, when _____. . . . . ❑
7. Bleeding gums. . . . . ❑
8. Jaw problems (temporamandibular joint). . ❑
9. Tension Headaches. . . . . ❑
10. Clench or grind your teeth. . . . . ❑
11. Jaw clicking or popping. . . . . ❑
12. Dental Implants. . . . . ❑

_____ _____
Signature Date