Dr. Stephanie A. Vondrak
Dr. Ashley A. Rainbolt

[MEDICAL HISTORY]

Have you been under the care of a medical doctor in the past two years for anything other than a routine physical or checkup: __Yes __No

If **yes**, for what? _____

Physician's Name _____ Phone _____

Address _____ State _____ Postcode _____

Have you taken any medications or drugs during the past two years? __Yes __No

Are you currently taking any medications, drugs, diet pills or holistic/herbal medications? __Yes __No

If **yes**, please list name, dosage, and condition associated to medication: _____

_____

_____

Are you allergic to any medications or substances? __Yes __No

If **yes**, please list _____

Do you use tobacco? __Yes __No

Women: Are you currently:

Pregnant/Trying to get pregnant	Y / N	If **yes**, how far along? _____
Nursing	Y / N	
Taking Birth Control	Y / N	

Do you have, or have you had, any of the following?

□Heart (surgery, disease, attack)
□Chest Pain
□Congenital Heart Disease
□Heart Murmur
□High Blood Pressure
□Mitral Valve Prolapse
□Artificial Heart Valve
□Heart Pacemaker
□Rheumatic Fever
□Arthritis/Rheumatism
□Cortisone Medications
□Swollen Ankles
□Diet (Special/Restricted)
□High Cholesterol
□Angina
□Stroke
□Stomach Ulcers
□Diabetes
□Thyroid Issues
□Glaucoma
□Emphysema
□Chronic Cough
□Tuberculosis
□Asthma
□Hay Fever
□Latex Sensitive
□Allergies/Hives
□Sinus Troubles
□Cancer
□Canker Sores
□Radiation Therapy
□Chemotherapy
□Cold Sores
□Hemophilia
□Bruise easily
□Liver Disease
□Kidney Trouble
□Neurological Disorders
□Epilepsy/Seizures
□Fainting/Dizzy Spells
□Nervous/Anxious
□Artificial Joints
□Tumors
□Hepatitis (A, B, C, D)

Do you have or have you had any disease, health condition or concern not listed?

If **yes**, please list _____

Comments:

_____

_____

I understand the above information is necessary to provide dental care to all patients in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature _____ **Date** _____