PATIENT MEDICAL HISTORY

Please Print Clearly **Raul A. Ortiz DMD PA**

First Name	MI	Last Name	Today's Date
Street Address		City and State	Zip Code
Home Phone:		Cell Phone:	Work Phone:
E-Mail		SSN	DOB
Employer		Family Dentist	Family Physician
Sex: Male Female		How Did Hear About Our Office? Web Page: Doctor: (Name) Friend: Other:	

Check the ones that apply

- o Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? ________________
- o Has there been any change in your general health with in the past year? If yes, explain ________________
- o Are you under the care of a physician for a current problem? If yes, explain. ________________
- o Have you been hospitalized within the past 5 years? If yes, explain. ________________
- o Have you received therapy for alcoholism or drug addiction in the past 5 years? ________________
- o Have you ever had any ALLERGIC OR ADVERSE REACTION to anesthetic/antibiotics/medications? ________________
- o Is there any condition concerning your health that the doctor should know? ________________
- o Have you had abnormal bleeding with previous extractions, surgery or trauma? Do you bruise easily? ________________
- o Have you ever required a blood transfusion? ________________
- o Have you ever had surgery and/or radiation/chemotherapy for cancer, tumor, growth or other condition? ________________
- o Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor. ________________
- o Are you required to take antibiotics prior to dental treatment? ________________
- o Women: Are you Pregnant, Nursing or on Birth Control Pills? ________________

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

____	High Blood Pressure	_____	Low Blood Pressure	_____	Diabetes
____	Heart murmur or Mitral Valve Prolapsed	_____	Chest Pain, Angina	_____	Stomach ulcers, Colitis
____	Joint Prosthesis/replacement (hip, knee, etc)	_____	Swollen ankles, arthritis, or joint disease	_____	Hepatitis, Jaundice, Liver Disease
____	Rheumatic fever or rheumatic heart disease	_____	Cardiac pacemaker	_____	Kidney problems/Dialysis
____	Congenital heart disease	_____	Heart surgery	_____	Psychiatric treatment
____	Heart attack, stroke, bypass	_____	Delay in healing	_____	Fainting spells
____	Prosthetic (artificial) heart valve	_____	Tuberculosis	_____	Epilepsy
____	Blood disorder E.g., anemia	_____	Emphysema or Lung Problems	_____	TMJ joint problems
____	Venereal disease	_____	Asthma	_____	Immune system problems
____	Eye disease or glaucoma	_____	Bronchitis	_____	Thyroid problems
____	**Allergy to Latex/sulfa/aspirin/penicillin**	_____	Sinus Trouble/Hay Fever	_____	**None of the above**

o Please list your medications: ____

____

Emergency Contact: (Name) ______________________________ Phone: ______________________

Signature: ______________________________