John C. Rogers, D.D.S

Rogers Dental®

MEDICAL HISTORY

Patient Name

Medical Alert

10522 South Cicero Ave. Suite 404 Oak Lawn, IL 60453 • 708-422-7733 • www.RogersDental.com

Physician's Name		Phone Number	

Have you had any medical care within the past two years?	No	Yes

If yes, describe:	

Have you ever been told or do you take a pre-medication before a dental appointment?	No	Yes

Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?	No	Yes

If yes, please list name and dosage	

Are you aware of having an allergic (or adverse) reaction to any substance or medication?	No	Yes

If yes, please specify:	

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or Reclast (a once a year shot)	No	Yes

Are you allergic or sensitive to latex?	No	Yes

Have you been a patient in the hospital during the past 3 years?	No	Yes

Please check off any of the following to indicate which you have had, or have at present.

	Heart (Surgery, Disease, Attack)		Kidney Trouble		Tumors
	Chest Pain		Ulcers		Hepatitis A B C (circle)
	Congenital Heart Disease		Diabetes		A.I.D.S./H.I.V. Positive
	Heart Murmur		Thyroid Problems		Cold Sores/ Fever Blisters
	High/Low Blood Pressure		Diseases of the Eyes		Hemophilia
	Mitral Valve Prolapse		Contact Lenses		Sickle Cell Disease
	Artificial Heart Valve/ Pacemaker		Emphysema		Bruise Easily
	Swollen Ankles		Chronic Cough		Liver Disease/Yellow Jaundice
	Have you had any transplants?		Tuberculosis		Neurological Diseases
	Stroke		Asthma		Epilepsy or Seizures
	Rheumatic Fever		Hay Fever/Allergy/Hives		Fainting or Dizzy Spells
	Arthritis		Sinus Trouble		Nervous/Anxious
	Autoimmune Diseases		Radiation Therapy		Psychiatric/Psychological Care
	Artificial Joints (hip, knee, etc.)		Chemotherapy		

Have you lost or gained more than 10 pounds in the past year?	No	Yes

Do you have or have you had any disease, condition, or problem not listed?	No	Yes

If yes, please list:	

Women: Are you pregnant or think you could be pregnant?	No	Yes	Months		Nursing?	No	Yes

Do you use birth control prescriptions?	No	Yes

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

Patient Signature (or Legal Guardian): _____ Date: _____

Medical History Reviewed on: _____ Dental Professional Signature: _____