REVOLUTION
·DENTISTRY·

Medical History

Patient Name: _____ Age:_____

Have you been under the care of a physician during the past two years? _____

If yes, for what? _____

Physician's name: _____ Phone:_____

Address: _____ State: _____ Zip code: _____

List of current medications: _____

_____

Current allergies to medications or environment factor, please list: _____

Indicate which of the following you have had, or have currently. Please answer "yes" or "no" to each item.

Chest Pain	Yes	No	Asthma.....	Yes	No
Heart (Surgery, disease, attack)..	Yes	No	Hay Fever	Yes	No
Congenital heart defect	Yes	No	Latex allergy	Yes	No
High blood pressure	Yes	No	Allergies or Hives	Yes	No
Heart murmur.....	Yes	No	Sinus trouble	Yes	No
Mitral valve prolapse	Yes	No	Tumors	Yes	No
Artificial heart valve	Yes	No	Radiation therapy	Yes	No
Heart pacemaker	Yes	No	Chemotherapy	Yes	No
Rheumatic fever	Yes	No	Hepatitis A or B or C	Yes	No
Arthritis/Rheumatism	Yes	No	Venereal disease	Yes	No
Cortisone Medications	Yes	No	Herpes (oral or genital)	Yes	No
Swollen Ankles	Yes	No	HPV (Human Papaloma Virus)..	Yes	No
Stroke	Yes	No	AIDS	Yes	No
Diet (Special/restricted)	Yes	No	HIV Positive	Yes	No
Artificial joints (hip, knee, etc.) ..	Yes	No	Cold sores/fever blisters	Yes	No
Kidney trouble	Yes	No	Blood transfusions	Yes	No
Ulcers	Yes	No	Hemophilia	Yes	No
Diabetes	Yes	No	Sickle cell disease	Yes	No
Thyroid problems	Yes	No	Liver disease	Yes	No
Glaucoma.....	Yes	No	Jaundice	Yes	No
Contact lenses	Yes	No	Neurological disorders	Yes	No
Sleep apnea/snoring	Yes	No	Epilepsy or Seizures	Yes	No
Chronic cough	Yes	No	Fainting or dizzy spells	Yes	No
Emphysema	Yes	No	Nervous/Anxious	Yes	No
Tuberculosis	Yes	No	Psychiatric/psychological care	Yes	No

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

If yes, please list: _____

_____

For female patients, are you:

Pregnant? Yes ____ Months or No. Nursing? Yes No Taking birth control? Yes No

I understand the above information is necessary to provide me with the 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 may have my permission to ask the respective health care provider or agency, which may release such information to me. I will notify Revolution Dentistry and my doctor of any changes in my health and medications.

Patient/Guardian Signature:_____ Date: _____

Schaumburg 113 East Schaumburg Road I Schaumburg, IL 60194 I 847-301-1818 I Fax 847-301-1981 schaumburg@revolution-dentistry.com
Skokie 4905 Old Orchard Center I Suite 221 I Skokie, IL 60077 I 847-674-2463 I Fax: 847-674-2496 skokie@revolution-dentistry.com
South Elgin 480 Briargate Drive I South Elgin, IL 60177 I 847-841-1818 I Fax: 847-301-1981 southelgin@revolution-dentistry.com