The Cedar Rapids Dental Center

(319) 365-0534
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Patient:_____ **Birth date:** ____/____/____ **Today's Date:** ____/____/____

Name and city of your physician:_____

Date of last physical:_____

Name and city of your specialist:_____

Reason for last visit to specialist:_____

Has there been a change in your general health in the past year? Please explain: _____

List recent and/or major surgeries:_____

Medical History: (Circle those that apply)

Acid Reflux / GERD / Ulcers	Colitis	Hepatitis A, B, C
ADD / ADHD	COPD	Kidney Issues
AIDS / HIV	CPAP (use of)	Liver Disease
Alcohol Abuse	Dental Anxiety	Lupus
Allergies (seasonal)	Depression	Mitral Valve Prolapse
Anxiety	Diabetes Type I	Pacemaker
Arthritis	Diabetes Type II	Periodontal Disease
Artificial Heart Valve	Dementia	Psychiatric Illness
Artificial Joints	Drug Abuse	Radiation (head / neck)
Asthma	Emphysema	Rheumatic Fever
Autism	Epilepsy / Seizures	Sinus Problems
Bleeding (abnormal)	Fainting Spells	Sjögren's Syndrome
Blood Clots	Fever Blisters / Cold Sores	Sleep Apnea
Blood Pressure (high)	Headaches (frequent)	Special Needs
Blood Pressure (low)	Heart Attack	Stroke
Cancer	Heart Disease	Thyroid Disease
Chemotherapy	Heart Murmur	Other
Cholesterol	Heart Surgery	None

Additional comments regarding conditions checked above: _____

Women: Are you Pregnant? If yes, #weeks / due date: _____

Do you use tobacco? If yes, type and frequency. If past user, quit date: _____

Medications:

Prescription and Over-the-Counter (OTC) medications patient takes: _____

Does patient need pre-med (antibiotic) before dental treatment? If yes, list reason: _____

Allergies

List allergies and reactions: _____