Port Royal Dentistry Medical History Form

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will receive. Thank you for taking the time to complete this form.

Patients Name (please print)**:**_____**Date of Birth:** _____ **Date:**_____

Are you under a Physician's care now? **Yes** or **No** If **Yes**; physician's name and last visit date: _____

- Are you currently taking any blood thinners? **Yes** or **No**
- Are you currently taking any osteoporosis medications? **Yes** or **No**
- Do you use tobacco products? **Yes** or **No**

Women: Are you.....

- Pregnant/Trying to get pregnant? **Yes** or **No** If **yes**; due date: _____
- If pregnant, please list OBGYN contact information: _____
- Nursing? **Yes** or **No**

ALLERGIES – Select all that apply:

Aspirin		Latex		Local Anesthetics	
Codeine		Penicillin		NSAIDS	
Erythromycin		Sulfa		Seasonal Allergies	

Please list any other allergies you have or N/A for no known allergies:_____

MEDICATIONS: Please list any medications (including vitamins/supplements) you are currently taking. Please provide list if greater than space provided.

MEDICAL CONDITIONS: Check all that apply

- ❑ Anemia
- ❑ Angina
- ❑ Artificial Heart Valve
- ❑ Blood Disease
- ❑ Congenital Heart Defect
- ❑ Heart Attack, if so, when?_____
- ❑ Heart Condition
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Irregular Heart Beat
- ❑ Leukemia
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse, if so, with or without regurgitation_____
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Stents
- ❑ Stroke, if so, when?_____
- ❑ Acid Reflux
- ❑ Gastrointestinal Disease
- ❑ GERD
- ❑ Stomach Ulcers
- ❑ AIDS
- ❑ Arthritis
- ❑ Cancer, if yes. List type_____
- ❑ Chemotherapy, if so, when _____
- ❑ Radiation, if so, when?_____
- ❑ Herpes
- ❑ HIV Positive
- ❑ HPV
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ STD
- ❑ Tumors/Growths
- ❑ Diabetes
- ❑ Thyroid Problem
- ❑ Cirrhosis
- ❑ Hep A/B/C
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Asthma
- ❑ Bronchitis
- ❑ COPD
- ❑ Emphysema
- ❑ Mouth Breathing
- ❑ Respiratory Problems
- ❑ Sinus Problems
- ❑ Sleep Apnea
- ❑ Snoring
- ❑ Tuberculosis
- ❑ Use Inhaler
- ❑ Asperger's
- ❑ Autism
- ❑ Cerebral Palsy
- ❑ Dizzy/Fainting
- ❑ Epilepsy/Seizures
- ❑ Nervous Disorder
- ❑ Artificial Joints
- ❑ Osteoporosis
- ❑ Detached Retina
- ❑ Glaucoma

Please list any other medical conditions you may have:_____

***Consent**: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.*

_____ _____

Patient's Signature: (parent if minor) **Date:**

Port Royal Dentistry
1869 North Paris Ave.
Port Royal, SC 29935
843.521.1869.

Dental Disclosure Form

I, _____, (**Print Name**) give authorization to Dr. Peipei Yu and/or Port Royal Dentistry staff to release and discuss my dental information with the following:

e.g. Relative or/and friend

1. **Name:** _____ **Relationship to Patient:**_____

   Contact Number: _____

2. **Name:** _____ **Relationship to Patient:**_____

   Contact Number: _____

3. **Name:** _____ **Relationship to Patient:**_____

   Contact Number: _____

_____ _____

Signature **Date**

PORT ROYAL DENTISTRY

Information Update:

Name (please print): _____

Preferred Name: _____

Date of Birth: _____

Mailing Address: _____

_____

Phone Number: Cell:_____

Home:_____

Email Address: _____

Emergency Contact: Name:_____

Phone Number:_____

Relationship to Patient:_____

Name of Current Dental Insurance Provider:_____

_____ _____

Patient Signature: **Date:**