Houston (713) 347-6833
Dallas (214) 550-7323

MOBILE DENTAL ASSOCIATES

Info@mobiledentalassociates.com
(713) 347-6844

MEDICAL HISTORY

Patient Name: _____ ___ _____ _____ _____
First M.I. Last Nickname DOB

Question	Yes	No	Please explain "Yes" answers.
Is the patient currently being treated for any symptom or condition?	☐	☐	
Is the patient currently taking blood thinners?	☐	☐	
Has the patient taken Fosamax, Boniva, Actonel or other Bisphosphonates?	☐	☐	
Is the patient experiencing unusual weight loss or malnutrition?	☐	☐	

Allergies and Medical Symptoms and Conditions (Please check all that apply)

Patient is Allergic To:		Symptoms & Conditions		Symptoms & Conditions		Symptoms & Conditions	
☐	NO KNOWN ALLERGIES	☐	Arthritis	☐	Fainting Spells	☐	Nervous System Disorder
☐	Amoxicillin	☐	Asthma	☐	Fever Blisters	☐	Pacemaker
☐	Erythromycin	☐	Autoimmune Disease	☐	Frequent Headaches	☐	Premedicate
☐	Penicillin	☐	Blood Clotting Problems	☐	Frequent Dry Mouth/Sjogren	☐	Radiation Therapy
☐	Other Antibiotics	☐	Blood Transfusion	☐	Gag Reflex	☐	Rheumatic Fever
☐	Barbiturates / Sleeping Pills	☐	Bronchitis	☐	Gall Bladder Trouble	☐	Rheumatic Heart Disease
☐	Codeine	☐	Bulimia	☐	Heart Arrythmia	☐	Rheumatoid Arthritis
☐	Other Narcotics	☐	Cancer/Tumor or Growth	☐	Heart Attack	☐	Seizures
☐	Epinephrine	☐	Cardiovascular Disease	☐	Heart Disease	☐	Sexually Transmitted Disease
☐	Other Local Anesthetics	☐	Chemotherapy	☐	Heart Murmur	☐	Shortness of Breath
☐	Iodine	☐	Chest Pain (upon exertion)	☐	Hepatitis	☐	Sickle Cell Anemia
☐	Latex Rubber	☐	Congenital Heart Defect	☐	Herpes Cons	☐	Sinusitis
☐	Sulfa Drugs	☐	Congestive Heart Failure	☐	High Blood Pressure	☐	Skeletal Disease/Disorder
Symptoms and Conditions ↓ ↓ ↓		☐	Constipation	☐	Hives	☐	Skin Conditions
		☐	Convulsions	☐	Jaundice	☐	Sleep Disturbance/Walking
☐	AIDS/HIV infection	☐	C.O.P.D.	☐	Joint Replacement	☐	Stomach Upsets
☐	Abnormal Bleeding	☐	Damaged Heart Valve	☐	Kidney	☐	Stomach Ulcers
☐	Alzheimer's Disease	☐	Dementia	☐	Leukemia	☐	Stroke
☐	Anemia	☐	Diabetes	☐	Liver Disease	☐	Thyroid
☐	Angina	☐	Diarrhea (Persistent)	☐	Low Blood Pressure	☐	Tuberculosis
☐	Ankles Swell	☐	Emphysema	☐	Lupus	☐	Urinary Tract Infections
☐	Anorexia	☐	Environmental Allergies	☐	Mental Health Problems	☐	Urinates Frequently
☐	Arteriosclerosis	☐	Epilepsy	☐	Mitral-Valve Prolapse	☐	Other conditions not listed?

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PHYSICIAN INFORMATION

DOCTOR(S) Currently caring for the patient	NAME	CONTACT PHONE #
PCP (Primary Care Physician)		
Cardiologist (If Applicable)		

RECENT HOSPITALIZATIONS (LAST 24 MONTHS)

DATE	REASON(S)

PRESCRIPTIONS

If you or your loved one are living in a memory care or assisted living community and you are not certain of the current medications, please assist us by signing a Health Records Release Form allowing us access to the patient's Health Records, Medication List(s) and Community Face Sheet and then submitting to the community's Director of Nursing or Wellness Director.

Copies can be emailed to: info@mobiledentalassociates.com or Faxed to 713-347-6844

Please Note: We may not be able to proceed with dental treatment without this information.

DRUG NAME	QUANTITY	DOSAGE PER DAY

If additional space is needed, please email additional medication list to info@mobiledentalassociates.com.

SIGNATURE ACKNOWLEDGEMENT

To the best of my knowledge, I have provided the most accurate patient information related to _____
Print Patient's Full Name

and therefore, release the treating dentist from any responsibility that may arise from any omissions or inaccuracies.

_____ _____ _____
Signature | Please Print Signer's Name | Date

Signer's Legal Authority? ☐ Patient(self) ☐ Responsible Party ☐ Guardian ☐ Power of Attorney ☐ Conservator ☐_____

Signer's Relationship To Patient? ☐ Patient(self) ☐ Daughter ☐ Son ☐ Spouse ☐ Mother ☐ Father ☐_____