DR. MARTIN RAHN INC.
Oceanside Dental

PATIENT CONCERNS	MEDICAL ALERT

CONFIDENTIAL PATIENT HISTORY
PERSONAL INFORMATION

Mr.
Miss
Ms.
Mrs. NAME ______________________________
Dr.

ADDRESS ______________________________

CITY ______________ PROV. __________ POSTAL CODE ______________

PHONE: RES. ______________ BUS. ______________ DATE OF BIRTH ____/____/____
Month Day Year

REFERRED BY ______________ PHYSICIAN ______________

NAME OF PARENTS OR GUARDIAN ______________________________

MEDICAL HISTORY

Please check (✔) YES NO

1. Have you ever had a serious illness or are you under the care of a physician now? ☐ ☐
2. Have you had a medical examination in the last year? .... ☐ ☐
3. Do you use any prescription, non-prescription, herbal meds or vitamins regularly? .... ☐ ☐
4. Have you ever had any of the following diseases? (Please check all that apply)
   hepatitis, jaundice, diabetes, high blood pressure, tuberculosis, any lung disease, cancer, AIDS, venereal disease, heart attack or heart disease, heart murmur, stroke, epilepsy, thyroid disease, kidney disease, mental or nervous disease, arthritis or rheumatic fever, stomach problems.
5. Do you have any allergies? If yes, which ones? .... ☐ ☐
6. Do you have any artificial implants such as hip, knee, breast etc.? .... ☐ ☐
7. Have you had Botox injections? .... ☐ ☐
8. Have you ever experienced any unusual reaction to any drugs or local anaesthetics? ☐ ☐
   If yes, please explain ______________________________
9. Do you bruise easily or bleed abnormally? ______________ ☐ ☐
10. Do you have any blood disorders such as anaemia (thin blood)? .... ☐ ☐
11. Do you have a tendency to faint? .... ☐ ☐
12. Any disease, condition, or problem not listed above that you think the doctor should know about?
    If yes, please explain ______________________________
13. WOMEN ONLY – Are you pregnant? (Due date? ______________) .... ☐ ☐

MEDICAL HISTORY UPDATE ON: ______________ ______________

______________ ______________ ______________ ______________

DENTAL HISTORY

1. How long has it been since your last dental visit? __________ Name of Dentist ______________
2. Do you have any oral habits such as clenching, grinding your teeth or nail biting? ... ☐ ☐
3. Do your teeth bleed when you brush or floss? .... ☐ ☐
4. Are you happy with the appearance of your teeth? .... ☐ ☐
5. Do you have worn, chipped or broken dental restorations? .... ☐ ☐
6. Do you get food caught between any teeth? Where? ______________ ☐ ☐
7. Do you have frequent headaches, migraines, neck, back or shoulder pain? .... ☐ ☐
8. Have you had any injury, surgery or x-ray therapy to your face or jaws? .... ☐ ☐
9. Have you had orthodontic work? .... ☐ ☐
10. Present complaint? ______________________________

____

____

____

____

Date ______________ Patient's Signature ______________