ORCHARD DENTAL GROUP™
Perri Kauls, D.D.S.
Robert Marolt, D.D.S.
12 Long Lake Road
Number 12
Mahtomedi, MN 55115
651-770-2699
www.orcharddentalgroupmn.com

MEDICAL HISTORY

PATIENT NAME_____ Date of Birth_____

Are you under a physicians care now? Yes No If yes, please explain _____

Physician's Name_____ Phone #_____ Address_____

Have you ever been hospitalized or had a major operation? Yes No If yes, for what conditions _____

Have you ever had a serious head or neck injury? Yes No If yes, when _____

Are you taking any medications, pills or drugs? Yes No If yes, please list_____

Have you ever taken, Phen-Fen or Redux? Yes No Do you use tobacco? Yes No Do you use E-Cigs? Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Are you on a special diet? Yes No If yes, what does it consist of_____

Have you ever been told by a Physician that you need an antibiotic before dental work? Yes No If yes, reason_____

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa

☐ Other If yes, please explain: _____

OVER

ORCHARD DENTAL GROUP™
Perri Kauls, D.D.S.
Robert Marolt, D.D.S.
12 Long Lake Road
Number 12
Mahtomedi, MN 55115
651-770-2699
www.orcharddentalgroupmn.com

MEDICAL HISTORY

Do you have, or have you had any of the following?

AIDS/HIV Positive Yes No	Drug Addiction Yes No	High Blood Pressure Yes No	Shingles Yes No
Alzheimer's Disease Yes No	Easily Winded Yes No	Hives or Rash Yes No	Sickle Cell Disease Yes No
Anaphylaxis Yes No	Emphysema Yes No	HPV Vaccination Yes No	Sinus Trouble Yes No
Anemia Yes No	Epilepsy or Seizures Yes No	Hypoglycemia Yes No	Spina Bifida Yes No
Angina Yes No	Excessive Bleeding Yes No	Irregular Heartbeat Yes No	Stomach/Intestinal Disease Yes No
Arthritis/Gout Yes No	Excessive Thirst Yes No	Kidney Problems Yes No	Stroke Yes No
Artificial Heart Valve Yes No	Fainting Spells/Dizziness Yes No	Leukemia Yes No	Swelling of Limbs Yes No
Artificial Joint Yes No	Frequent Cough Yes No	Liver Disease Yes No	Thyroid Disease Yes No
Asthma Yes No	Frequent Diarrhea Yes No	Low Blood Pressure Yes No	Tonsillitis Yes No
Blood Disease Yes No	Frequent Headaches Yes No	Lung Disease Yes No	Tuberculosis Yes No
Blood Transfusion Yes No	Genital Herpes Yes No	Lyme Disease Yes No	Tumors or Growths Yes No
Breathing Problem Yes No	Glaucoma Yes No	Mitral Valve Prolapse Yes No	Ulcers Yes No
Bruise Easily Yes No	Hay Fever Yes No	Pain in Jaw Joints Yes No	Venereal Disease Yes No
Cancer Yes No	Heart Attack/Failure Yes No	Parathyroid Disease Yes No	Yellow Jaundice Yes No
Chemotherapy Yes No	Heart Murmur Yes No	Psychiatric Care Yes No	
Chest Pains Yes No	Heart Pace Maker Yes No	Radiation Treatments Yes No	
Cold Sores/Fever Blisters Yes No	Heart Trouble/Disease Yes No	Recent Weight Loss Yes No	
Congenital Heart Disorder Yes No	Hemophilia Yes No	Renal Dialysis Yes No	
Convulsions Yes No	Hepatitis A Yes No	Rheumatic Fever Yes No	
Cortisone Medicine Yes No	Hepatitis B or C Yes No	Rheumatism Yes No	
Diabetes Yes No	Herpes Yes No	Scarlet Fever Yes No	

Have you ever had any serious illness not listed above? Yes No If yes, what and when_____

Comments_____
_____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian_____Date_____

History Review

Dentist Signature_____Date_____