Milford Dental Group

Anna Chisilenco Raho D.D.S.

Medical History

Patient name: ___________________________________ Date: ________________________

Physician's Name:________________________________ Date of Last Visit:_______________

Have you had any serious illness or operations:_____Yes_____No

If yes, describe:____

(Women) Are you pregnant:_____ Are you Nursing:_____Yes_____No

Emergency Contact name and number: _______________________ Relation: _____________________

Please check if you have had any of the following:

___Abnormal Bleeding
___Alcohol/Drug abuse
___Anemia
___Arthritis, Rheumatism
___Artificial Heart Valves
___Artificial Joints, When ____
___Asthma
___Back Problems
___Blood Disease
___Cancer
___Chemical Dependency
___Chemotherapy
___Circulation Problems
___Cortisone Treatment
___Cough, Persistent
___Cough up Blood
___Congenital Heart Disease
___Diabetes, Type ___
___ High Cholesterol
___Epilepsy
___Fainting
___Glaucoma
___Headaches
___Heart Murmur
___Heart Lesions
___Heart Problems
___Hemophilia
___Hepatitis
___Hernia Repair
___High Blood Pressure
___Low Blood Pressure
___HIV/AIDS
___Jaw pain
___Kidney Problems/Disease
___Liver Disease
___Mitral Valve Prolapse
___ Psychiatric care
___Pacemaker
___Sleep Apnea
___Radiation Treatment
___Respiratory Disease
___Rheumatic Fever
___Scarlet Fever
___Shortness of Breath
___Skin Rash
___Stroke
___Swelling of Feet or Ankles
___Thyroid Problems
___Tobacco Habit
___Tonsillitis
___Tuberculosis
___Ulcer
___Venereal Disease

Did you ever have to pre-medicate prior to dental work for heart issues or joint replacement?_______

List Current Medications:____

List Allergies:____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Milford Dental Group, Anna Chisilenco Raho D.D.S., if there are any changes or updates to my health.

Print name of Patient, Guardian or Personal Representative: __________________________________

Signature: ____ Date: ______________

Signature of Doctor or Hygienist: _______________________________________Date_______________