Dr. Ronald A. Livingston **Dr. Blake G. Livingston**
Family Dentistry & Dental Implants

13724 Woodward **Highland Park, Michigan 48203** **313-883-3050**

PATIENT MEDICAL HISTORY

Today's Date _____

Name _____ **Date of Birth** _____

Address _____ **Cell Phone** _____

In the following questions circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Has there been any change in your general health within the past year	YES	NO
Are you presently under the care of a physician	YES	NO
Are you presently taking any prescription medications	YES	NO
Have you had any serious illness or operation	YES	NO
Have you ever had shortness of breath or difficulty breathing	YES	NO
Are you allergic to any medications Penicillin ☐ Codeine ☐ Other ☐	YES	NO
Have you ever used chewing tobacco	YES	NO
Are you on blood thinners	YES	NO
Have you ever been hospitalized for any reason	YES	NO

WOMEN

Are you pregnant Week # _____	YES	NO
Are you breast-feeding	YES	NO
Have you ever taken medication for bone loss - Osteoporosis	YES	NO

Have you ever had any of the following conditions or medical problems?

Abnormal Bleeding	YES	NO	**Kidney Dialysis**	YES	NO
Artificial Joints - Hip / Knee / Other	YES	NO	Fainting Spells	YES	NO
Asthma or Hay Fever	YES	NO	**Hepatitis, Jaundice or Liver Disease**	YES	NO
Cancer	YES	NO	**High Blood Pressure**	YES	NO
Radiation Treatment	YES	NO	**HIV+, AIDS** or other immunosuppressive disorders	YES	NO
Chemotherapy	YES	NO			
Congenital Heart Defect	YES	NO	Psychiatric Problems	YES	NO
Heart Problems (Attack, Surgery, Pacemaker)	YES	NO	Are you a smoker	YES	NO
Mital Valve Prolapse	YES	NO	Sinus Problems	YES	NO
Artificial Heart Valves	YES	NO	Stroke	YES	NO
Diabetes	YES	NO	**Tuberculosis (TB)**	YES	NO
Drug Abuse	YES	NO	Venereal Disease (STD's)	YES	NO
Emphysema	YES	NO	Epilepsy or Seizures	YES	NO

_____ _____

Signature of Patient Signature of Dentist

_____ _____ _____ _____ _____ _____

Date Initials Date Initials Date Initials

Pre Med: YES NO

MEDS:

Comments: _____