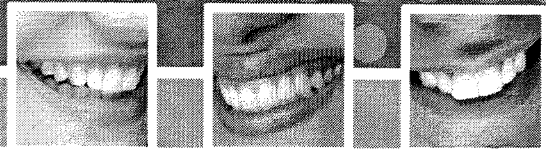
Riverside Dental
1521 Doctors Ct
Watertown WI 53094

(920)262-2176

riversidedental@riversidednt.com
www.riversidedental.us



Health History

Please fill out to the best of your knowledge:

Patient Name: ______ Last ______ First ______ MI ______ Preferred Name

Physician's Name and Facility Location:

______

Are you under a physician's care?

◯ Yes ◯ No

If yes, please expain:

______

Have you ever been hospitalized or had a major operation?

◯ Yes ◯ No

If yes, please explain:

______

Please list all prescription and over the counter medications that you take:

______

Do you use tobacco?

◯ Yes ◯ No

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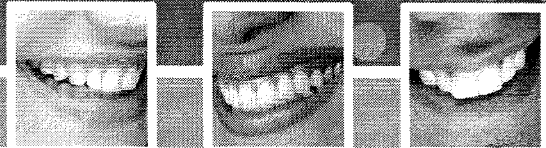

Women, Are you pregnant?

◯ Yes ◯ No

Please list any allergies:

Please check any medical conditions you have or have had:

- [ ] AIDS/HIV
- [ ] Alzheimer's Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood Disorders
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Cold Sores/Fever Blisters
- [ ] Congenital Heart Disorder
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Emphysema/COPD
- [ ] Epilepsy/Seizures
- [ ] Excessive Bleeding
- [ ] Excessive Thirst
- [ ] Fainting/Dizzy Spells
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Headaches
- [ ] Heart Attack
- [ ] Heart Disease/Trouble
- [ ] Heart Murmur
- [ ] Heart Pacemaker
- [ ] Hemophilia
- [ ] Hepatitis A, B, or C
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Jaundice
- [ ] Kidney Problems
- [ ] Leukemia
- [ ] Liver Disease
- [ ] Low Blood Pressure

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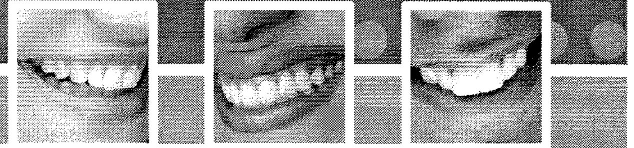

- [ ] Lung Disease
- [ ] Osteoporsis/Bisphosphonate Use
- [ ] Parathyroid Disease
- [ ] Radiation Treatments
- [ ] Rheumatic Fever
- [ ] Shingles
- [ ] Sinus Trouble
- [ ] Stomach/Intestinal Problems
- [ ] Thyroid Disease
- [ ] Tumors or Growths
- [ ] Venereal Disease
- [ ] Mitral Valve Prolapse
- [ ] Pain in Jaw Joints
- [ ] Psychiatric Care
- [ ] Renal Dialysis
- [ ] Scarlet Fever
- [ ] Sickle Cell Disease
- [ ] Spina Bifida
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Ulcers

Please list any other medical condition not listed above:

____

* [ ] By checking this box, I acknowledge I have answered all questions to the best of my ability.

Signature: ____________________

Date: __________

Response Date: __________