Ruby Canyon Dental
2552 Patterson Rd, Grand Junction, CO 81505
(970) 241-1313
www.rubycanyondental.com/

HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

General Health Information

A healthy mouth contributes to a healthy body and many systemic diseases are linked to oral health issues. To provide you with the best care we need to learn a little about your health.

Are you currently under the care of a physician?	
Physician phone number	
Date of last physical exam	
Has a physician or dentist recommended that you take antibiotics before having dental work done?	
Have you had a serious illness, operation, or been hospitalized in that past 5 years?	
Have you had a heart valve replacement or heart surgery?	
Have you had an organ or bone marrow/stem cell transplant?	
Have you had a fever (100.4 degrees F or above) in the last 72 hours?	

Medical Conditions

Do you have, or have you been diagnosed with, any of the following conditions?	
Heart (Cardiac) Health	
Breathing (Respiratory) Health	
Cancer	
Liver (Hepatic) Health	
Kidney (Renal) Health	
Blood (Circulatory) Health	
Brain (Neurological)/Mental Health	
Autoimmune Disease	
Digestive Health	
Eye (Vision) Health	
Diabetes	
Osteoporosis/osteopenia	
Thyroid disease	
Artificial Joint	

Women Only (Men, please just hit "no")	
Any other medical condition we should know of?	

Allergies

Do you have any medication, material, or environmental allergies?	

Medications & Other Products/Substances

Please check all medications you are currently taking	
Are you taking any blood thinners (such as Coumadin, Warfarin, Xarelto, Pradaxa, Plavix, heparin or Aspirin)?	
Are you taking any medication to treat osteoporosis or Paget's disease?	
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	
Are you taking hormonal replacements?	
Do you use any form of tobacco or nicotine products?	
Do you use any form of marijuana products?	
Do you use alcohol?	
Are you taking any pain medications?	
Are you taking any Antidepressants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	
Are you taking any Allergy or Asthma medications?	
Are you taking any Antibiotics?	
Do you take any other prescriptions and/or over-the-counter medicines, vitamins, herbs, or supplements?	

Signature

I have answered the above questions completely, accurately and to the best of my ability.

Patient's signature: Date:

Doctor's signature: Date: