

# 4

## MEDICAL HISTORY *continued*

Your current physical health is:  Good  Fair  Poor

Are you taking any prescription / over-the-counter or supplemental drugs?

Yes  No

Please list each one: \_\_\_\_\_

Do you smoke or use tobacco in any other form?  Yes  No

Have you ever taken Fosamax, or any other bisphosphonate?  Yes  No

Have you ever taken Phen-Fen?  Yes  No

For Women: Are you using a prescribed method of birth control?  Yes  No

Are you pregnant?  Yes  No Week #: \_\_\_\_\_

Are you nursing?  Yes  No

### Have you ever had any of the following disease or medical problems? (Please circle option that applies)

- |                                                                                             |                                                                                      |
|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia / Radiation Treatment          | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia / Abnormal Bleeding |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves    | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis                             | <input type="checkbox"/> Y <input type="checkbox"/> N High / Low Blood Pressure      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                                | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion                     | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy                 | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems                |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect               | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes                              | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing                  | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Drug / Alcohol Abuse                  | <input type="checkbox"/> Y <input type="checkbox"/> N Severe / Frequent Headaches    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema / Glaucoma                  | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy / Seizures / Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters / Herpes               | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Stroke                 | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)              |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur                          | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers / Colitis               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery / Pacemaker             | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease               |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

### Are you allergic to any of the following?

- |                                                                          |                                                                        |                                                                    |
|--------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin            | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin     | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine            | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry / Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex            | <input type="checkbox"/> Y <input type="checkbox"/> N Other        |

Please list any other drugs / materials that you are allergic to: \_\_\_\_\_

# 5

## DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment?  Yes  No

Are you currently in pain?  Yes  No

Have you ever had a serious / difficult problem associated with any previous dental work?  Yes  No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?  Yes  No

Your current dental health is:  Good  Fair  Poor

Do you like your smile?  Yes  No

Do your gums ever bleed?  Yes  No

Have you ever had periodontal disease?  Yes  No

How many times a week do you floss? \_\_\_\_\_ a day do you brush? \_\_\_\_\_

Type of bristles?  Hard  Medium  Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Payment is due in full at the time of treatment unless prior arrangements have been approved.



Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

### MEDICAL HISTORY UPDATE

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_