Medical History

Name _____ **Preferred Name** _____

Yes	No	
☐	☐	1. **Are you currently under medical treatment?** _____
☐	☐	2. **Within the last 5 years, have you ever been hospitalized for any surgical operation or serious illness? If so, please explain** _____
☐	☐	3. **Do you have a cardiac pacemaker?**
☐	☐	4. **Do you use tobacco products?**
☐	☐	5. **Do you use controlled substances?**
☐	☐	6. **Do you take blood thinners (i.e. COUMADIN, PLAVIX, PRADAXA, EFFIENT, BRILINTA)**
☐	☐	7. **Are you taking any non-prescription medication(s)? If so, please list** _____

_____

☐	☐	8. **Do you take any prescription medication(s)? If so, please list** _____

_____

9. Please circle if you are allergic to or have had any reactions to the following:

Any metals (e.g. nickel, mercury, etc) Aspirin Barbiturates Codeine Latex rubber

Local anesthetics (e.g. Novocain) Penicillin Sedatives Sulfa Drugs Other _____

10. Women only:	**Yes**	**No**
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐

11. Do you have or have you had any of the following?

	Yes	No
HIV Disease	☐	☐
Dialysis	☐	☐
Heart Murmur	☐	☐
Joint Replacement or Implant	☐	☐
Kidney Diseases	☐	☐
Lupus	☐	☐
Mitral Valve Prolapse	☐	☐
Rheumatic Fever	☐	☐
Spleen Removal	☐	☐
Allergies/Hay Fever	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer type _____	☐	☐
Diabetes type _____	☐	☐
Herpes	☐	☐

	Yes	No
Emphysema	☐	☐
Epilepsy/Convulsions	☐	☐
Crohn's Disease	☐	☐
Glaucoma	☐	☐
Heart Attack	☐	☐
Heart Disease/Angina	☐	☐
Heart Surgery (Cath, Bypass)	☐	☐
Jaundice/Hepatitis type _____	☐	☐
High Blood Pressure	☐	☐
Liver Disease	☐	☐
Chemo/Radiation Therapy	☐	☐
Sexually Transmitted Infection	☐	☐
Thrombocytopenia	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Tuberculosis	☐	☐
GERD (Heart burn)	☐	☐

_____

Any Conditions not listed _____

Medical History, continued

Physician _____ **Office Phone** _____

Do you have or have you <u>ever</u> had a history of the following conditions:

	Yes	No
Multiple Myeloma	☐	☐
Metastatic Cancer	☐	☐
Breast Cancer	☐	☐
Lung Cancer	☐	☐
Paget's Disease	☐	☐
Osteoporosis	☐	☐
Osteomalacia	☐	☐
Osteonecrosis of the jaws	☐	☐

Do you take or have you <u>ever</u> taken any of the following medications or any other Bisphosphonate medication?

	Yes	No
Zometa	☐	☐
Aredia	☐	☐
Fosamax	☐	☐
Boniva	☐	☐
Actonel	☐	☐
Didronel	☐	☐
Skelid	☐	☐
Prolia	☐	☐

12. Dental History for All Patients:

When was your last dental visit? _____

What was the reason for that visit? _____

Have you had injury to teeth or face? Explain: _____

Do you think you have clenching/grinding issue? _____

Are happy with appearance of your teeth? _____

Do you think you could benefit from braces? _____ **Cosmetics?** _____ **Whitening?** _____

Do you wish to discuss something privately with the dentist? _____

Do you snore or have sleeping problems? _____

13. Administrative and social questionnaire.

Where did hear about us? _____

Why did you choose our office? _____

Did you have a chance to visit our website at ?_____

if so, did you find it helpful (in what)? _____