Patient Medical History

Although dental practitioners primarily treat the mouth, it is important that we obtain a thorough medical history from our patients. Undisclosed health issues you may have and/or medications/substances you are taking may impair treatment or result in serious side effects. Thank you for answering the following questions.

Have you been under the care of a medical doctor during the past 5 years? *If so, explain* ..... Yes No

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Have you ever been hospitalized or had an operation? *Discuss* ..... Yes No

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Are you taking any medications, pills or drugs (including non-prescription drugs such as aspirin)? *If so, list* ..... Yes No

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Have you ever had a serious head or neck injury? *List please* ..... Yes No

Are you on a special diet? ..... Yes No

Do you use tobacco products? *List please* ..... Yes No

Have you ever taken Phen-Phen*, Redux or any other diet pills? *List please* ..... Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? *List please* ..... Yes No

Are you allergic to any medication or substance (ex: Latex, Penicillin, Nickel)? *List please* ..... Yes No

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Do you have or have you ever had any of the following? Please circle

Heart Trouble/ Disease	Yes No	Bleeding Problem	Yes No	Hepatitis A (Infectious)	Yes No	HIV Positive	Yes No
Heart murmur*	Yes No	Leukemia	Yes No	Hepatitis B	Yes No	Genital Herpes	Yes No
Angina/ Chest Pain	Yes No	Blood Transfusion	Yes No	Hepatitis C (non A non B)	Yes No	Drug Addiction	Yes No
Heart Attack/ Failure	Yes No	Swelling of Ankles	Yes No	Yellow Jaundice	Yes No	Cold Sores	Yes No
Congenital Heart Disorder	Yes No	Lung Disease	Yes No	Kidney Problems	Yes No	Stroke	Yes No
Mitral Valve Prolapse*	Yes No	Asthma	Yes No	Renal Dialysis	Yes No	Convulsions	Yes No
Scarlet Fever	Yes No	Emphysema	Yes No	Thyroid Disease	Yes No	Epilepsy or Seizures	Yes No
Rheumatic Fever*	Yes No	Tuberculosis	Yes No	Arthritis/ Gout	Yes No	Fainting or Dizziness	Yes No
Artificial Heart Valve*	Yes No	Cancer	Yes No	Rheumatism	Yes No	Glaucoma	Yes No
Heart Pace Maker	Yes No	Radiation Therapy	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Heart Surgery	Yes No	Chemotherapy	Yes No	Cortisone Medicine	Yes No	Nervousness	Yes No
High Blood Pressure	Yes No	Stomach Ulcers	Yes No	Artificial Joint, Implant*	Yes No	Psychiatric Treatment	Yes No
Blood Disease	Yes No	Diabetes	Yes No	Venereal Disease	Yes No	Alzheimer's Disease	Yes No
Sickle Cell Disease	Yes No	Liver Disease	Yes No	AIDS	Yes No	Allergies (Pollen / Dust)	Yes No

Have you ever had any other illness, condition, or problem not listed above? *Discuss* ..... **Yes No**

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Date of last medical exam? ..... Family Physician? ..... Telephone? ( ) …….. - ……..…….

Women *(please check):* ⬭ Are you pregnant or think may be pregnant ⬭ Nursing ⬭ Taking oral contraceptives

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibilityto inform the dental office of any changes in medical status.

CONSENT:

The undersigned hereby authorizes Center for Implant & Esthetic Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the treating doctor to make a thorough diagnosis of the patient's dental needs. I further understand that some of my photographs can be used for educational purposes without revealing my identity. I also authorize the treating doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with restoring my dental health, and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered.

Signature of Patient, Parent or Guardian .....Date.....Doctor's Signature .....