## Medical Information

**Patient Name:** _____

Last First MI

**Are you now under the care of a physician?** **O** Yes **O** No

**Physician Name and phone number:**

_____

**Has there been any change in your general health within the past year?** **O** Yes **O** No

**If yes, please specify:** _____

_____

**Have you had a serious illness, operation or been hospitalized in the past 5 years?** **O** Yes **O** No

**If yes, what was the illness or problem?:** _____

_____

**Please list any prescription or over the counter medicines you are taking including vitamins, natural or herbal preparations, and/or dietary supplements:** _____

_____

_____

## Please indicate if you have or have had any of the following diseases or problems:

**Have you had an orthopedic total joint replacement?** **O** Yes **O** No

**If yes, please specify:** _____

**Are you scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's Disease?** **O** Yes **O** No

**If yes, please specify:** _____

**Since 2001, were you or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, Xgeva) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma or metastatic cancer?** **O** Yes **O** No

**Date treatment began:** _____

**Do you have any cancer history in your family?** **O** Yes **O** No

**If yes, who and what type of cancer?:** _____

_____

## For Women Only:

**Are you pregnant?** **O** Yes **O** No

**If yes, how many weeks?:** _____

**Are you taking birth control pills or hormonal replacement medications?** **O** Yes **O** No

**Are you nursing?** **O** Yes **O** No

**Have you had a positive pap smear?** **O** Yes **O** No

## Please indicate if you have or had any of the following diseases or problems. (The following marked with an * require premedication with antibiotics before any dental treatment is done):

☐ Artificial (prosthetic) heart valve * ☐ Previous infective endocarditis * ☐ Damaged valves in transplanted heart *

☐ Congenital heart disease (CHD) * **If you have congenital heart disease (CHD), please indicate if you have had:**

☐ Unrepaired cyanotic CHD * ☐ Repaired CHD (completely) in the last 6 months * ☐ Repaired CHD with residual defects *

## Please indicate if you have or have had any of the following:

- ☐ Cardiovascular disease
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Congestive heart failure
- ☐ Damaged heart valves
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Other congenital heart defects
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Abnormal bleeding
- ☐ Anemia
- ☐ Blood transfusion
- ☐ Hemophilia
- ☐ AIDS or HIV infection
- ☐ Arthritis
- ☐ Autoimmune disease
- ☐ Rheumatoid arthritis
- ☐ Systemic lupus erythematosus
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinus trouble
- ☐ Tuberculosis
- ☐ Cancer treatment (Chemo/Radiation)
- ☐ Chest pain upon exertion
- ☐ Chronic pain
- ☐ Diabetes Type I or II
- ☐ Eating disorder
- ☐ Malnutrition
- ☐ Gastrointestinal disease / stomach problems
- ☐ G.E. Reflux / persistent heartburn
- ☐ Ulcers
- ☐ Thyroid problems
- ☐ Stroke
- ☐ Glaucoma
- ☐ Hepatitis, jaundice or liver disease
- ☐ Epilepsy
- ☐ Fainting spells or seizures
- ☐ Neurological disorders
- ☐ Mental health disorders
- ☐ Recurrent infections
- ☐ Kidney problems
- ☐ Night sweats
- ☐ Osteoporosis
- ☐ Persistent swollen glands in neck
- ☐ Severe headaches / migraines
- ☐ Severe or rapid weight loss
- ☐ Sexually transmitted disease
- ☐ Sleep disorder
- ☐ Snoring
- ☐ Excessive urination
- ☐ Coumadin / blood thinner therapy
- ☐ Human papillomavirus (HPV) infection
- ☐ High cholesterol
- ☐ Chronic obstructive pulmonary disease

## Are you allergic to or have you had a reaction to:

- ☐ Local anesthetics
- ☐ Aspirin
- ☐ Penicillin
- ☐ Barbituates, sedatives or sleeping pills
- ☐ Sulfa drugs
- ☐ Codeine or other narcotics
- ☐ Metals
- ☐ Latex (rubber)
- ☐ Iodine
- ☐ Hay fever / seasonal
- ☐ Animals
- ☐ Acrylic
- ☐ Tetracycline
- ☐ Erythromycin
- ☐ Food
- ☐ Other **Please specify:** _____

**Do you use controlled substances?** **O** Yes **O** No

**Please specify:** _____

**Do you drink alcoholic beverages?** **O** Yes **O** No

**If yes, how much alcohol have you drank in the last 24 hours?:** _____

**If yes, how much do you typically drink in a week?:** _____

**Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?** **O** Yes **O** No

**Name and phone number of physician/dentist making recommendation:** _____

_____

**Do you have any disease, condition, or problem not listed above that you think we should know about?** **O** Yes **O** No

**Please explain:** _____

## Authorization and Consent

I understand that the information that I have given 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. I will not hold the dentist, or any other staff member, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of these forms. I hereby consent to and authorize the dental office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I further understand that payment is due at the time of treatment unless prior arrangements have been made. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. Furthermore, I grant the dental practice permission to correspond to me via e-mail and/or text message.

Signature of Patient, Parent, or Guardian (Responsible Party):

**Signature:** _____ **Date:** _____

Relationship to Patient: _____