Medical Information

Patient: Submitted: 11/7/2024

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws.

PATIENT INFORMATION

First Name:
Last Name:
Date of Birth:

MEDICAL INFORMATION

Do you use tobacco (smoking, snuff, chew, vaping)?	Yes [ ] No [ ]
Do you consume alcohol or use recreational drugs?	Yes [ ] No [ ]
Have you had a serious illness, operation or been hospitalized in the past 5 years?	Yes [ ] No [ ]
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	Yes [ ] No [ ]
Are you currently under the care of a physician?	Yes [ ] No [ ]

***If you are currently under the care of a physician, please complete the "Physician Information" section.*

**PHYSICIAN INFORMATION

Physician Name: Physician Phone Number:
Date of last visit:

Did you have bloodwork completed as part of your last visit?	Yes [ ] No [ ]

HABITS

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Thumb/finger sucking	Yes [ ] No [ ]	Tongue Thrust	Yes [ ] No [ ]
Lip sucking/biting	Yes [ ] No [ ]	Speech problems	Yes [ ] No [ ]
Mouth breather	Yes [ ] No [ ]	Nail biting	Yes [ ] No [ ]

MEDICATION

Are you prescribed blood thinners? (Aspirin, Heparin, Warfarin, etc.)	Yes [ ] No [ ]
Have you ever taken any medications containing bisphosphonates (i.e. Fosamax and Boniva)?	Yes [ ] No [ ]
Are you currently taking any GLP-1 medications for weight loss?	Yes [ ] No [ ]
Are you taking any prescription or over the counter medication(s)?	Yes [ ] No [ ]

Please list all prescribed or over the counter medication(s).

Medical Information

Patient: Submitted: 11/7/2024

Medication	Dosage	Frequency

ALLERGIES

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Anesthesia	Yes [ ] No [ ]	Aspirin	Yes [ ] No [ ]
Barbiturates/sedatives/ sleeping pills	Yes [ ] No [ ]	Codeine or other narcotics	Yes [ ] No [ ]
Sulfa drugs	Yes [ ] No [ ]	Tetracycline/ Erythromycin/Penicillin/ Other antibiotics	Yes [ ] No [ ]
Jewelry/Metals	Yes [ ] No [ ]	Latex (rubber)	Yes [ ] No [ ]
Hay fever/ Seasonal		Yes [ ] No [ ]	
Do you have any allergies not listed above?		Yes [ ] No [ ]	

Please list any allergies not listed above:

Allergies

JOINT REPLACEMENT/IMPLANT

Yes [ ] No [ ]

Do you have any artificial orthopedic joints or had any orthopedic implants placed in your body?

Date Of Replacement or Implant:

HEART CONDITIONS

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Artificial (prosthetic) heart valve	Yes [ ] No [ ]	Congenital heart disease (CHD)	Yes [ ] No [ ]
Cardiovascular disease	Yes [ ] No [ ]	Chest pain / Angina	Yes [ ] No [ ]
Arteriosclerosis / Coronary artery disease	Yes [ ] No [ ]	Congestive heart failure	Yes [ ] No [ ]
Heart attack	Yes [ ] No [ ]	Heart murmur	Yes [ ] No [ ]
Low blood pressure	Yes [ ] No [ ]	High blood pressure	Yes [ ] No [ ]
Mitral valve prolapse	Yes [ ] No [ ]	Pacemaker	Yes [ ] No [ ]
Cardiac stent	Yes [ ] No [ ]	History of Endocarditis	Yes [ ] No [ ]

MEDICAL CONDITIONS, DISEASES, AND PROBLEMS

PLEASE MARK YES OR NO IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Pregnant/Nursing?	Yes [ ] No [ ]	Taking birth control pills or hormonal replacement?	Yes [ ] No [ ]
Hemophilia / Abnormal bleeding	Yes [ ] No [ ]	Blood transfusion	Yes [ ] No [ ]
Anemia	Yes [ ] No [ ]	Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)	Yes [ ] No [ ]
HIV + / AIDS	Yes [ ] No [ ]	Arthritis / Pain in joints	Yes [ ] No [ ]
Asthma / Breathing problems	Yes [ ] No [ ]	Tuberculosis	Yes [ ] No [ ]
Emphysema / Bronchitis / Persistent cough	Yes [ ] No [ ]	Sinus trouble	Yes [ ] No [ ]
Rheumatic fever	Yes [ ] No [ ]	Hearing or Vision Impairment	Yes [ ] No [ ]
Cancer / Chemotherapy / Radiation	Yes [ ] No [ ]	Chronic pain	Yes [ ] No [ ]
Diabetes	Yes [ ] No [ ]	Glaucoma	Yes [ ] No [ ]
Hepatitis / Jaundice / Liver disease	Yes [ ] No [ ]	Mental Health Conditions (e.g., anxiety, depression, bipolar)	Yes [ ] No [ ]
Neurological disorders	Yes [ ] No [ ]	Snoring	Yes [ ] No [ ]
Sleep disorder	Yes [ ] No [ ]	Severe / Rapid weight loss	Yes [ ] No [ ]
Eating disorder / Malnutrition	Yes [ ] No [ ]	Gastrointestinal disease	Yes [ ] No [ ]
Reflux / Persistent heartburn	Yes [ ] No [ ]	Sores / Ulcers in the mouth	Yes [ ] No [ ]
Thyroid problems	Yes [ ] No [ ]	Stroke	Yes [ ] No [ ]
Epilepsy / Seizures	Yes [ ] No [ ]	Dizziness / Fainting	Yes [ ] No [ ]
Recurrent Infections	Yes [ ] No [ ]	Kidney problems	Yes [ ] No [ ]
Night sweats	Yes [ ] No [ ]	Osteoporosis	Yes [ ] No [ ]
Persistent swollen glands in neck	Yes [ ] No [ ]	Frequent / Severe headaches	Yes [ ] No [ ]
Sexually transmitted	Yes [ ] No [ ]	Difficulty urinating /	Yes [ ] No [ ]

infection
Do you have any other diseases, conditions, problem, or special needs or accommodations not listed above?

Prostate
Yes [ ] No [ ]

Please list any other diseases, conditions, problem, special needs or accommodations not listed above.

Problems

SIGNATURE

I consent to use Electronic Records and Signatures: [ ]

I certify that 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 patients') health. I acknowledge that It is my responsibility to inform the dental team of any changes in medical status and I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.