The Center for Aesthetic & Implant Dentistry

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MEDICAL HISTORY QUESTIONNAIRE

First Name: _____ Last Name _____ Date _____

Date of Birth: _____ Age: _____ Sex: _____ Height _____ Weight _____

For the following questions, circle or select YES or NO, whichever applies.
Your answers are for our records only and will be kept confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. Physician Name _____ Phone _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
   Please explain _____
   _____
7 Have you had an artificial joint replacement (knee, hip, etc.)? What year? ..... Yes No
8 Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia)? Please circle one if yes ..... Yes No
9a. Are you taking any blood thinners? (Xarelto, Coumadin, Plavix, Pradaxa, Aggrenox, Aspirin) Please circle one if yes ..... Yes No
9b. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? ..... Yes No
   If so, please list _____
   _____
   _____
   _____
10. Do you have or have you had any of the following diseases or problems? If yes, please explain
    a. Artificial valves, heart murmur, or mitral valve prolapse ..... Yes No
    b. Rheumatic Heart Disease, damaged heart valves ..... Yes No
    c. Heart trouble, heart attack, angina, stroke, arteriosclerosis or any other heart condition ..... Yes No
       1. Chest pain upon exertion? ..... Yes No
       2. Shortness of breath after mild exercise? ..... Yes No
       3. Do your ankles swell? ..... Yes No
    d. High Blood Pressure ..... Yes No
    e. Sinus trouble ..... Yes No
    f. Asthma ..... Yes No
    g. Fainting spells or seizures ..... Yes No
    h. Diabetes ..... Yes No
    i. Hepatitis, jaundice or liver disease ..... Yes No
    j. Frequent or recurring mouth sores ..... Yes No
    k. Thyroid problems ..... Yes No
    l Respiratory problems, emphysema, bronchitis, COPD ,etc. ..... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
    n. Osteoporosis ..... Yes No
    o. Stomach ulcer or colitis ..... Yes No
    p. Kidney disease ..... Yes No
    q. Tuberculosis ..... Yes No
    r. Persistent cough or cough that produces blood ..... Yes No
    s. Persistent swollen neck glands ..... Yes No

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t. Low blood pressure ..... Yes No
u. Epilepsy or neurological disorder ..... Yes No
v. Cancer ..... Yes No
w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

11. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
12. Do you have any blood disorder such as anemia? ..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ..... Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other *(please list name of medication)* ..... Yes No
16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain _____
17. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain _____
18. Do you smoke or chew Tobacco? ..... Yes No
    How much? _____ How long ? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes No
20. Are you wearing contact lenses? ..... Yes No
21. Are you wearing removable dental appliances? ..... Yes No
22. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

Are you pregnant or any chance you might be pregnant? ..... Yes No
Are you nursing? ..... Yes No
Are you taking birth control pills? (If so, antibiotics and some other medications may interfere with the effectiveness of birth control. Consult with your physician.) ..... Yes No

Chief Dental Complaint

_____
_____
_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient's Signature _____ Date _____