Parkside Dental

Patient Name:_____ Patient Date Of Birth:_____ Date:_____

Medical History

DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS: (CHECK ALL THAT APPLY)

☐ Active Tuberculosis ☐ Persistent cough greater than a 3-week duration

☐ Cough that produces blood ☐ Been exposed to anyone with tuberculosis

SELECT THE APPROPRIATE ANSWER

Are you under care of a physician? ☐ Yes ☐ No

Physician Name: Physician Phone: Last Physical Exam:

Are you in good health? ☐ Yes ☐ No

Has there been any changes in your general health within the last year? ☐ Yes ☐ No

If yes, what condition was being treated?

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

If yes, what was the illness or problem?

Do you wear contact lenses? ☐ Yes ☐ No

Have you had an orthopedic total joint (hip, knee, elbow, or finger) replacement? ☐ Yes ☐ No

Date: If yes, have you had any complications?

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

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (Aredia, Zometa, XGEVA) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's Disease, Multiple myeloma, or Mestatic cancer? ☐ Yes ☐ No

Date Treatment Began?

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Please mark your response to indicate if you have or have not had any of the following diseases or problems.

Do you use controlled substance (drugs)? ☐ Yes ☐ No

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No

If yes, how interested are you in stopping? ☐ Very ☐ Somewhat ☐ Not Interested

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, how much alcohol did you drink in the last 24hrs? _____

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

MEDICATIONS- Please list any medications you are currently taking including Vitamins and Dietary supplements:

☐ Please check this box if you are taking additional medications not listed here, and bring along to your appointment.
☐ Please check this box if Physician or Previous dentist recommended you to take antibiotics prior to your dental treatment.
☐ **Please check this box if you do not take any medications, vitamins, or dietary supplements**

If you are biologically female, are you:

Pregnant? ☐ Yes ☐ No Number of Weeks: _____

Taking birth control pills or hormonal replacements? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

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ALLERGIES – Are you allergic to or have you had a reaction to: If checked, specify type of reaction.

☐ Local Anesthetics	
☐ Aspirin	
☐ Penicillin or other antibiotics	
☐ Barbiturates, sedatives, or sleeping pills	
☐ Sulfa	
☐ Codeine or other narcotics	
☐ Metals	
☐ Latex (rubber)	
☐ Iodine	
☐ Hay Fever / Seasonal	
☐ Animals	
☐ Food	
☐ Other Allergy:	

☐ **I do not have any allergies**

MEDICAL CONDITIONS – Please select all that apply:

☐ Artificial (prosthetic) heart valve
☐ Previous infective endocarditis
☐ Damaged valves in transplanted heart
☐ **I do not have any of the above medical conditions**

Congenital Heart Disease (CHD)

☐ Unrepaired, Cyanotic CHD
☐ Repaired (completely) in the last 6 months
☐ Repaired CHD with residual defects
☐ **I do not have any of the above CHD**

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MEDICAL CONDITIONS- Please select all that apply:
Except for the conditions listed previous, antibiotic prophylaxis is no longer recommended for any other form of CHD

- ☐ 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
  Date: ☐
- ☐ Hemophilia
- ☐ HIV + / AIDS Infection
- ☐ Other Condition: ☐

- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus Erythematosus
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinus Trouble
- ☐ Tuberculosis (TB)
- ☐ Cancer/Chemo/Radiation Therapy
- ☐ Chest Pain upon exertion
- ☐ Chronic Pain
- ☐ Diabetes Type I or II
- ☐ Eating Disorder
- ☐ Malnutrition
- ☐ Gastrointestinal Disease
- ☐ G E Reflux/ Persistent Heartburn
- ☐ Stomach Ulcers
- ☐ Thyroid Problems
- ☐ Stroke

- ☐ Glaucoma
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Epilepsy
- ☐ Fainting Spells or Seizure
- ☐ Neurological Disorders
  Specify: ☐
- ☐ Sleep Disorder
- ☐ Snoring
- ☐ Mental Health Disorders
  Specify: ☐
- ☐ Recurrent Infections
  Type: ☐
- ☐ Kidney Problems
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Persistent Swollen Glands in Neck
- ☐ Severe Headaches/Migraines
- ☐ Severe or Rapid Weight Loss
- ☐ Sexually Trans. Disease
- ☐ Excessive Urination
- ☐ **I do not have any medical conditions**

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I certify that I have read and understood the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability and that any questions that I may have, had been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Legal Guardian Name:

Relationship to patient (if you are the patient, print "self"):

By signing this form, I certify that the above information is true and correct to the best of my knowledge.

Patient or Legal Guardian Signature:

Date (MM/DD/YYYY):