PATIENT MEDICAL AND DENTAL HISTORY

Todays Date

Name				Age	Birthdate
Guest Address				City, State, Zip	
Social Security No			Home #	Work #	Cell #
Weight	Height	Race	Sex	Email Address	
Employer Name					
Employer Address					
Name Of Insurance				Group Number	
Responsible Party/Insured's Name				Relation to Insured	
Marital Status				Spouse's Name	
Person to Notify in Emergency/Number					
Physician's Name				Physician's Number	
Driver's License Number/State					

MEDCAL HISTORY

Please Circle Yes (Y) of No (N) after the following questions:

1. Has there been any change in your general health during the past year?..... Y N
2. Are you under a physicians care other than for routine physicals?..... Y N
3. Date of last physical _____
4. Have you had any serious illness or operations Y N
   Describe _____
5. Do you have, or have you had:
   a. Rheumatic fever or rheumatic heart disease?. Y N
   b. Heart murmur?..... Y N
   c. Cardiovascular Disease (heart trouble) coronary artery disease, angina, stroke?..... Y N
   d. High blood pressure?..... Y N
   e. Hay fever? ..... Y N
   f. Sinus trouble?.....Y N
   g. Asthma?..... Y N
   h. Hepatitis, Jaundice, Liver Disease?.....Y N
   i. Arthritis?.....Y N
   j. Fainting Spells or Seizures (Epilepsy)?.....Y N
   k. Diabetes?.....Y N
   l. Ulcers?..... Y N
   m. Kidney or Bladder Disease? ..... Y N
   n. Low Blood Pressure?.....Y N
   o. Thyroid Condition? ..... Y N
   p. Anemia or Other Blood Disorder? ..... Y N
   r. Cancer, Chemotherapy, or Radiation? ..... Y N
   s. Artificial Joint/Implants?..... Y N
   t. Emphysema?..... Y N
   u. Tuberculosis?..... Y N
6. Do you bruise easily or have prolonged bleeding? Y N
7. Have you ever been hospitalized?..... Y N
   Reasons:_____
8. Women: Are you pregnant?..... Y N
9. Do you have any other condition not listed above that may affect your treatment?... Y N
10. Do you smoke? How much?..... Y N
11. Are you allergic to or have you had an adverse reaction to:
    a. Antibiotics(penicillin,sulfa,tetracycline) Y N
    b. Sedatives or tranquilizers? ..... Y N
    c. Aspirin? ..... Y N
    d. Codeine or other painkillers? ..... Y N
    e. Iodine? ..... Y N
    f. Other allergies_____
12. Do you believe you are immunosuppressed or HIV positive? ..... Y N
13. Are you taking any medication that may affect your immune system? ..... Y N
14. Do you have glaucoma? Y N
15. Have you had prolonged fever,coughing blood, or chest pain? ..... Y N
16. Are you using any of the following?
    a. Antibiotics or sulfa drugs? ..... Y N
    b. Anticoagulants (blood thinners)? .... Y N
    c. High blood pressure medicines? ..... Y N
    d. Heart medications (Digitalis,Inderal, Nitroglycerin)? ..... Y N
    e. Steroids (Cortisone, etc.)? ..... Y N
    f. Birth Control Pills? ..... Y N
    g. Insulin or diabetic drugs? ..... Y N

*List Medications or drugs you are currently taking below:

Medications	Indications	Side Effects

Please Circle Yes (Y) or No (N) after the following questions:

1. Have you ever been diagnosed or treated for Osteoporosis or Osteopenia? ….. Y N
2. Have you ever taken any of these medications?
   - Etdronate (Didronel)……Y N
   - Tiludronate (Skelid)……..Y N
   - Alendronate (Fosamax)……..Y N
   - Risedronate (Actonel)……..Y N
   - Ibandronate (Boniva)……...Y N
   - Pamidronate (Aredia)……...Y N
   - Zoledronate (Zometa) ……Y N
3. Have you ever received chemotherapy treatment (IV or oral)? ..... Y N

WOMEN

4. Have you ever been diagnosed or treated for multiple myeloma or breast cancer? Y N

MEN

5. Have you ever been diagnosed or treated for multiple myeloma or prostate cancer? Y N

If you answered yes to any of the above questions, please give your physicians information.

Name and number of Primary MD _____

Name and number of Oncologist _____

Dental History

Please Circle Yes (Y) or No (N) after the following questions:

1. Do you have problems with you TMJ (jaw joints)? ……. Y N
2. Are any of your teeth sensitive to cold, heat, or sweets? …… Y N
3. Have you had any serious trouble associated with previous treatment? ……. Y N
4. Do your gums bleed when you brush your teeth? ……... Y N
5. Do you have pain in or near your ears? ……. Y N
6. Do you have any injuries or inflamed areas in your mouth? …… Y N
7. Have you experienced any growths or sore spots in your mouth? …… Y N
8. Have you ever had Novocaine anesthetic? …… Y N
9. Any reactions or allergic symptoms to Novocaine? …… Y N
10. Any difficult extractions in the past? ……... Y N
11. Prolonged bleeding following extractions in the past? …… Y N
12. Do you have any dental complaints presently? ……. . Y N
13. If so specify _____
14. When was your last full dental examination? _____
15. When was your last full mouth x-ray taken? _____
16. When was your last dental cleaning? _____

Responsible Party

I am aware that payment is due at the time of service and methods of payment include Cash, Check, Mastercard, Visa , American express and care credit (dental interest free monthly payments).

I hereby certify that the above information is true and in addition authorize Exact Dentistry, PA, and staff under his direction to perform dental/oral surgical procedures to restore and/or preserve my overall dental/oral health. I am aware that if I do not give a 24-hour notice of cancellation I will be charged a $20.00 per half hour fee.

_____ _____

Signature (patient or parent if minor) Date

For Doctor's Use Only

EVALUATION OF MEDICAL HISTORY

Date	Signature	Assessment/Reassessment

Medical Consultation Required ☐ ☐ Consultation received ☐ ☐