

CNY PERIODONTICS AND IMPLANTS

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PERIODONTICS DENTAL IMPLANTS TM DISORDER
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MEDICAL HISTORY

NAME: _____

ARE YOU IN GOOD HEALTH? _____ ARE YOU PRESENTLY UNDER MEDICAL TREATMENT? _____

IF SO, PLEASE TELL ME WHAT FOR _____

ARE YOU PRESENTLY TAKING ANY PRESCRIPTION OR OTC MEDICATIONS? LIST: _____

DO YOU HAVE OR HAVE YOU EVER HAD:

- | | | | |
|--------------------------------|--|-----------------------------------|--|
| RESPIRATORY PROBLEMS/EMPHYSEMA | <input type="checkbox"/> YES <input type="checkbox"/> NO | DIABETES | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CARDIOVASCULAR ISSUES/SURGERY | <input type="checkbox"/> YES <input type="checkbox"/> NO | EPILEPSY OR NEUROLOGICAL PROBLEMS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HEPATITIS OR LIVER DISEASE | <input type="checkbox"/> YES <input type="checkbox"/> NO | ARTIFICIAL/JOINT REPLACEMENT | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| BLOOD/ANEMIA DISORDER | <input type="checkbox"/> YES <input type="checkbox"/> NO | DEMENTIA/ALZHEIMER'S | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| BLOOD THINNER MEDS | <input type="checkbox"/> YES <input type="checkbox"/> NO | KIDNEY TROUBLE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HIGH BLOOD PRESSURE | <input type="checkbox"/> YES <input type="checkbox"/> NO | IMPLANTED DEVICE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| MENTAL HEALTH PROBLEMS | <input type="checkbox"/> YES <input type="checkbox"/> NO | LOW BLOOD PRESSURE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| AUTOIMMUNE DISORDER | <input type="checkbox"/> YES <input type="checkbox"/> NO | CANCER | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| AIDS/HIV | <input type="checkbox"/> YES <input type="checkbox"/> NO | NONE | <input type="checkbox"/> YES <input type="checkbox"/> NO |

HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL? _____

DO YOU USE TOBACCO? IF SO, HOW MUCH? _____

PAST SURGICAL PROCEDURES _____

HAVE YOU HAD A SURGICAL PROCEDURE THAT REQUIRES A PREMEDICATION FOR DENTAL WORK? _____

HAVE YOU EVER HAD AN UNUSUAL REACTION TO ANY DENTAL DRUGS OR MEDICINE? _____

HAVE YOU EVER EXPERIENCED PROLONGED BLEEDING AFTER A DENTAL PROCEDURE? _____

ARE YOU WEARING REMOVABLE DENTAL APPLIANCES? _____

DO YOU HAVE ANY KNOWN ALLERGIES (LATEX, LOCAL ANESTHETICS, PENICILLIN, CODEINE, OTHER) _____

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM YOU THINK I SHOULD KNOW ABOUT? _____

WOMEN ONLY: ARE YOU PREGNANT OR NURSING? _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST OR ANY OTHER MEMBER OF HIS/HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE OF PATIENT

DATE

SIGNATURE OF DENTIST

DATE