CFD MEDICAL/DENTAL HISTORY(new)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
Name of Primary Care Physician.	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, or supplements? PLEASE LIST ALL.	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you drink alcohol? If so how much/often.	Yes No	If yes
Do you use tobacco? cigar, cigarettes, chewing tobacco?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes
Do you use cortisone medicine?	Yes No	If yes

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics
- ☐ Pine nuts

Other? ☐ If yes

Have you ever had allergic anaphylaxis? Yes No

Dental Information

Question	Answer
Do your gums bleed?	Yes No
Have you had any perio (gum) treatments?	Yes No
Do you grind your teeth?	Yes No
Do you get cold sores?	Yes No
Are you teeth sensitive?	Yes No
Do you have dental pain?	Yes No
Do you have mouth sores?	Yes No
Do you snore?	Yes No
Is your mouth dry?	Yes No
Do you have any clicking/popping?	Yes No
Do you wear dentures or partials?	Yes No
Do you need to take premedication?	Yes No

Do you have, or have you had, any of the following?

Condition	Answer
Artificial Heart Valve	Yes No
Asthma	Yes No
Lung disease	Yes No
Tuberculosis	Yes No
Severe or Rapid Weight Loss	Yes No
High Blood Presure	Yes No
Breathing Problems	Yes No
Thyroid Problems	Yes No
Abnormal Bleeding	Yes No
Osteoporosis	Yes No
Fainting Spells or Seizures	Yes No
Drug Addiction	Yes No
Venereal disease	Yes No
Sickle cell anemia	Yes No
Rheumatoid Arthritis	Yes No
Congenital Heart Disease	Yes No
Cardiovascular Disease	Yes No
Cancer/Chemo/ Radiation	Yes No
Heart Attack	Yes No
Gastrointestinal Disease	Yes No
Ulcers	Yes No
Low Blood Pressure	Yes No
Hepatitis B or C	Yes No
Epilepsy	Yes No
AIDS or HIV	Yes No
Artificial joint	Yes No
Blood disease	Yes No
Scarlet fever	Yes No
Previous Infected Endocarditis	Yes No
Kidney Problems/dialysis	Yes No
Sinus Trouble	Yes No
Severe Headaches/ Migraines	Yes No
Diabetes Type I or II	Yes No
Frequent Diarrhea	Yes No
Stroke	Yes No
Glaucoma	Yes No
Tonsillitis	Yes No
Heart Murmur	Yes No
Parathyroid Disease	Yes No
High cholesterol	Yes No
Alzheimers	Yes No
Mental Health disorder	Yes No
Anemia	Yes No
Angina	Yes No
Congestive Heart Failure	Yes No
Eating Disorder	Yes No
G.E. Reflux/ Persistent Heartburn	Yes No
Pacemaker	Yes No
Rheumatic Heart Disease	Yes No
Liver Disease	Yes No
Hemophilia	Yes No
Arthritis	Yes No
Hypoglycemia	Yes No
Shingles	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:___________