

Thank you for allowing Center for Advanced Dentistry to stay informed of your Medical and Personal Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

- |   |  |                                      |  |
|---|--|--------------------------------------|--|
| 1. Artificial (prosthetic) heart valve  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. Previous infective endocarditis  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Damaged valves in transplanted heart | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Congenital heart disease (CHD)   |  |
| 3. Heart disease/surgery                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Unrepaired, cyanotic CHD         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Heart murmur                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Repaired completely in last 6 months | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Heart Pacemaker                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Repaired CHD with residual defects   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Rheumatic fever/heart disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Mitral valve prolapse            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. High/low blood pressure              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Learning disability              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Mental health disorder               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Anorexia                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Bulimia                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Lung disease / COPD              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Tuberculosis                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Asthma                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Shortness of breath                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Respiratory ailments             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Emphysema                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | 42. Sinus trouble                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Diabetes type I or type II          | <input type="checkbox"/> Yes <input type="checkbox"/> No | 43. Thyroid problems                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Persistent swollen glands           | <input type="checkbox"/> Yes <input type="checkbox"/> No | 44. Kidney problems                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Sleep Disorder                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 45. Venereal disease                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. HIV Positive/AIDS/ARC               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 46. Alcohol addiction                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Drug dependency                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 47. Chemical dependency              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Blood disorders                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | EX. _____                            |  |
| 19. Anemia                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 48. Leukemia                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Prolonged bleeding                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 49. Hemophilia                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Sickle cell disease                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 50. Cancer                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Tumors                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 51. Chemotherapy                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Radiation therapy                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 52. Neurological disorders           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Epilepsy                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | 53. Stroke                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Arthritis/Rheumatism                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 54. Autoimmune Disease               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26. Artificial joint/prosthesis         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 55. Liver disease                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 27. Hepatitis A B C other (circle)      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 56. Ulcers                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28. Gastrointestinal disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No | 57. GERD (gastric reflux)            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 29. Hard of hearing                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 58. Glaucoma                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 30. Cortisone medication                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 59. Fainting spells                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 31. Organ transplant                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 60. Removal of spleen                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 32. Osteoporosis                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                      |  |

Current Medications: \_\_\_\_\_

Allergic to (circle all that apply): Latex Codeine Antibiotics PNC Sulfa Dental Anesthetics Other: \_\_\_\_\_

Any hospitalizations, serious illness or change in health status since your last visit?  Yes  No \_\_\_\_\_

Do you smoke Cigarettes, Pipe, Cigar, E-Cigarettes or use Smokeless Tobacco? \_\_\_\_\_ How Often? \_\_\_\_\_

**BIPHOSPHONATES:** Have you ever or are you currently taking or scheduled to begin taking: alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for osteoporosis or Paget's disease?  YES  NO

Do you have ARTIFICIAL JOINTS or HEART PROBLEMS that require you to take a PREMEDICATION prior to dental work?  YES  NO

Do you experience: HEADACHES?  YES  NO JAW PAIN?  YES  NO TMJ ISSUES?  YES  NO

Have you had BOTOX or DERMAL FILLERS before?  YES  NO

**Women:** Are you PREGNANT?  Yes  No Are you NURSING?  Yes  No Are you taking BIRTH CONTROL PILLS?  Yes  No

Patient /Guardian (if under age 18) Signature: \_\_\_\_\_ Date: \_\_\_\_\_