Teeth Tomorrow Manhattan
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MEDICAL INFORMATION

PATIENT NAME ______________________________ **BIRTH DATE**__________
Last First

Are you now under the care of a physician? ❑ **YES** ❑ **NO**

If Yes: Physician Name ____________________ Phone________________

Address____

Are you in good health? ❑ **YES** ❑ **NO**

If No, please list your concerns: ________________________________

Have there been any changes in your general health within the past year? ❑ **YES** ❑ **NO**

If Yes, what conditions are being treated?______________________________

Date of your last physical exam: ________________________________

Have you had a serious illness, operation or have been hospitalized in the past 5 years? ❑ **YES** ❑ **NO**

If Yes, what was the illness or problem?______________________________

Are you taking or have you recently taken any prescription or over-the-counter medications? ❑ **YES** ❑ **NO**

If Yes, please list all medications including vitamins, natural or herbal preparations and/or diet supplements:

__________ __________ __________ __________ __________ __________

Do you wear contact lenses? ❑ **YES** ❑ **NO**

Are you taking or have you taken any dietary drugs such as Pondimin (Fenfluramine), Redux (Dexphenflura-min) or Phen-fen (Fenflura mine - Phentermine)? ❑ **YES** ❑ **NO**

Are you taking or scheduled to begin taking either of the medications: Alendronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Tiludronate (Skelid), Etidronate (Didronel)?

If Yes, please list: ________________________________

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphos-phonates Aredia, Zometa, or Bonefos? ❑ **YES** ❑ **NO**

Joint replacement: Have you had an orthopedic total joint replacement? ❑ **YES** ❑ **NO**

If Yes, date of replacement:________________________________

ALLERGIES (check all that apply, and please list others)

Local Anesthetics ❑ **YES** ❑ **NO**
Penicillin or other Antibiotics ❑ **YES** ❑ **NO**
Sulfa Drugs ❑ **YES** ❑ **NO**
Codeine or other Narcotics ❑ **YES** ❑ **NO**
Hay Fever/Seasonal ❑ **YES** ❑ **NO**

Food ❑ **YES** ❑ **NO**
Aspirin ❑ **YES** ❑ **NO**
Metals ❑ **YES** ❑ **NO**
Latex ❑ **YES** ❑ **NO**
Iodine ❑ **YES** ❑ **NO**

Animals ❑ **YES** ❑ **NO**
Barbiturates, Sedatives or Sleeping Pills ❑ **YES** ❑ **NO**
Other:__________________
____

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems:

Condition	Yes	No
Artificial Heart Valves	❑ YES	❑ NO
Cardiovascular Disease	❑ YES	❑ NO
Angina	❑ YES	❑ NO
Coronary Artery Disease	❑ YES	❑ NO
Damaged Heart Valves	❑ YES	❑ NO
Low Blood Pressure	❑ YES	❑ NO
Congenital Heart Defects	❑ YES	❑ NO
Rheumatic Heart Disease	❑ YES	❑ NO
Anemia	❑ YES	❑ NO
Hemophilia	❑ YES	❑ NO
AIDS or HIV infection	❑ YES	❑ NO
Autoimmune Disease	❑ YES	❑ NO
Asthma	❑ YES	❑ NO
Bronchitis	❑ YES	❑ NO
Sinus Trouble	❑ YES	❑ NO
Rash	❑ YES	❑ NO
Chronic Pain	❑ YES	❑ NO
Malnutrition	❑ YES	❑ NO
Ulcers	❑ YES	❑ NO
Thyroid Problems	❑ YES	❑ NO
Glaucoma	❑ YES	❑ NO
Epilepsy	❑ YES	❑ NO
Neurological Disorders	❑ YES	❑ NO
Sleeping Disorder	❑ YES	❑ NO
Recurrent Infections	❑ YES	❑ NO
Kidney Problems	❑ YES	❑ NO
Osteoporosis	❑ YES	❑ NO
Severe or Rapid Weight Loss	❑ YES	❑ NO
Sexually Transmitted Disease	❑ YES	❑ NO
Coronary Artery Stent(s)	❑ YES	❑ NO
If Yes, date: ______		
Arteriosclerosis	❑ YES	❑ NO
Heart Attack	❑ YES	❑ NO
If Yes, date: ______		
High Blood Pressure	❑ YES	❑ NO
Pacemaker	❑ YES	❑ NO
Abnormal Bleeding	❑ YES	❑ NO
Blood Transfusion	❑ YES	❑ NO
If Yes, date: ______		
Arthritis	❑ YES	❑ NO
Rheumatoid Arthritis	❑ YES	❑ NO
Systemic Lupus Erythematosus	❑ YES	❑ NO
Emphysema	❑ YES	❑ NO
Tuberculosis	❑ YES	❑ NO
Cancer/Chemotherapy/Radiation tx	❑ YES	❑ NO
Diabetes	❑ YES	❑ NO
Gastrointestinal Disease	❑ YES	❑ NO
G.E. Reflux/Persistent Heartburn	❑ YES	❑ NO
Stroke	❑ YES	❑ NO
Hepatitis, Jaundice, Liver Disease	❑ YES	❑ NO
Fainting Spells or Seizures	❑ YES	❑ NO
Numbness	❑ YES	❑ NO
Sleeping Disorder	❑ YES	❑ NO
Mental Health Disorders	❑ YES	❑ NO
Specify: ______		
Night Sweats	❑ YES	❑ NO
Persistent Swollen Glands in Neck	❑ YES	❑ NO
Severe Headaches/Migraines	❑ YES	❑ NO
Excessive Urination	❑ YES	❑ NO

Can you walk up a flight of stairs without stopping? ❑ YES ❑ NO

Has a physician recommended that you take antibiotics prior to dental treatment? ❑ YES ❑ NO

Name of physician making the recommendation: ______

Do you have any disease, condition, or problem not listed above that you think I should know about? ❑ YES ❑ NO

If Yes, please explain: ______

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist(s) and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature ______ **Date:** ______