CONFIDENTIAL MEDICAL INFORMATION

Patient's Name:_____ **DOB:** _____ **Home Phone: ( )**_____

Street Address:_____ Work Phone: ( ) _____

City:_____ State:_____ ZIP:_____ E-Mail _____

Social Security Number:_____ Sex: ☐ Male ☐ Female

Emergency Contact: _____**Phone:** _____ **Relationship** _____

Spouse's Name:_____**Employer:** _____

Primary Physician: _____**Phone:**_____ **City & State**_____

Date of Last Physical Examination: _____Date of Last Blood Test/Workup:_____

Other Physicians or Specialists:

Name:_____ Specialty:_____ Phone:_____City & State:_____

Name:_____ Specialty:_____ Phone:_____City & State:_____

If you are completing this form for another person:

Your Name:_____Relationship:_____ Phone: ( ) _____

Within the last three years have you been hospitalized or had surgery? Yes No

If yes, please give reasons and dates: _____

Have you ever been instructed to take <u>ANY</u> medications or take <u>ANY</u> special precautions before any dental appointments?
☐ Yes ☐ No If yes, please explain: _____

1. Are you taking any medications for osteoporosis? ☐ Yes ☐ No

2. Are you taking any drugs, medications, or treatments at this time? ☐ Yes ☐ No
(If you brought a complete written list with you; please give that to the receptionist.)

Prescribed: _____

_____

Over-The-Counter Meds (such as aspirin, ibuprofen, allergy meds, sleeping aids, Vitamins, Natural or Herbal Preparations, and Dietary Supplements):

_____

_____

Are you having, or have you ever had radiation or chemotherapy treatments? ☐ Yes ☐ No

If yes, for how long? _____ Name of facility performing the therapy: _____

3. Are you allergic to, or have you ever experienced any unusual reaction to:

☐ Latex ☐ Metals or Jewelry ☐ Dental Anesthesia (Local/Novocaine)
☐ Fluoride ☐ Nitrous Oxide (Laughing Gas) ☐ General Anesthesia

4. Are you allergic to or have you ever had any reaction to the following drugs?

☐ Penicillin (or Related Drugs) ☐ Tranquilizers (Valium) ☐ Tetracycline ☐ Codeine
☐ Aspirin/Ibuprofen (Advil, Motrin, Nuprin) ☐ Keflex (Cephalexin) ☐ Sulfa Drugs ☐ Iodine
☐ NSAID (Celebrex, Vioxx, Anaprox) ☐ Clindamycin (Cleocin) ☐ Erythromycin

5. Have you had an allergic reaction or unusual response to <u>ANY</u> other medications, drugs, pills or treatments? ☐ Yes ☐ No

If yes, please list: _____

Continue on Back…

Do you have, or have you ever had any of the following? (Please check yes or no for each question.)

	YES	NO
6. a. Congenital Heart Defects	☐	☐
b. Angina or Chest Pains	☐	☐
c. Atherosclerosis	☐	☐
d. Congestive Heart Failure	☐	☐
e. Coronary Artery Disease	☐	☐
f. Heart Surgery	☐	☐
if Yes, Date: _____		
g. Heart Attack	☐	☐
If Yes, Date: _____		
h. Rhumatic Heart Disease/Rhumatic Fever	☐	☐
i. Heart Murmur	☐	☐
j. Heart Valve(s) Damage/Mitral Valve Prolapse	☐	☐
k. Artificial Heart Valve	☐	☐
l. Pacemaker	☐	☐
m. Stroke or CVA	☐	☐
n. High Blood Pressure	☐	☐
o. Low Blood Pressure	☐	☐
p. Anemia	☐	☐
q. Hemophilia or Bleeding Disorder	☐	☐
r. Excessive Bleeding from any Cut or Incident	☐	☐
s. Diabetes or Blood Sugar Problems	☐	☐
t. Any Artificial Joint, Joint Surgery, or Prosthesis	☐	☐
If yes, what joint or area? _____		
Date of surgery: _____		
u. Hepatitis, Jaundice, or Other Liver Problems	☐	☐
If Hepatitis, type? _____		
v. Any Form of Cancer	☐	☐
w. An Organ Transplant	☐	☐

	YES	NO
7. a. Asthma	☐	☐
b. Hay Fever, Skin or Food Allergies or Allergies in General	☐	☐
c. Sinus Problems	☐	☐
d. Tuberculosis, Emphysema or Lung Disorder	☐	☐
e. Skin Problems	☐	☐
f. A Sore or Wound that Bleeds Easily or Does not Heal	☐	☐
g. A Thyroid Problem or Disease	☐	☐
h. Arthritis	☐	☐
i. Glaucoma or any Eye Diseases	☐	☐
j. Epilepsy or Other Seizure Disorder	☐	☐
k. Any Kidney Problems	☐	☐
l. Ulcers, Acid Reflux, or Stomach Problems	☐	☐
m. A Compromised Immune System (Lupus, HIV, AIDS, Radiation Immune Problems,ect.)	☐	☐
n. An Active Sexually Transmitted Disease (STD)	☐	☐
o. Any Mental Health Issues	☐	☐
p. Been Treated for Any Psychiatric Condition	☐	☐
q. Do you smoke or chew tobacco?	☐	☐

8. Women Only:

	YES	NO
Are you pregnant?	☐	☐
If yes, what is your due date? _____		
Do you think that you might be pregnant?	☐	☐
Are you presently nursing?	☐	☐
Are you using birth control medication?	☐	☐
Are you taking hormone replacement therapy?	☐	☐

9. Do you have any other conditions, diseases, medical problems, or is there ANY other information that you would like us to know about or that we should be made aware of? ☐ Yes ☐ No If yes, please explain:

_____

_____

_____

Perna Dental

Patient Signature: _____ **Date:** _____

For Office Use Only

Provider: _____