Family Dental Care of Milford, Prof. Assn.

K. Drew Wilson, DMD, MAGD

Joshua T. Osofsky, DMD

Amanda Smith, DMD, MPH

Ward Gravel, DDS, FAGD

Patient Medical History – Personal and Confidential

Patient N	ame			Date of Birth						
Dental In	<u>formation</u>									
	Have you had perio	dontal treatment?		Yes	No					
	Yes	No								
	o your dental treatment? Yes	No								
Previous I	Dentist's Name		City	and State						
	nformation									
Physician	's Name		City ar	nd State						
Date of la	st physical exam									
Has there	been any change in you	r general health within the pa	in the past 5 years? YES / NO st year or are you being treate	ed for a condition now? YES / N	O (circle)					
Please cir	cle if you are allergic t	to the following:								
Local An	esthetics Aspirin	Penicillin or Other An	tibiotics Latex Fo	oods Barbiturates						
Sedatives	Sulfa Drugs	Codeine or Other Narcoti	cs Other							
Describe	Reaction									
		n or Herbal Medications Supplements/Remedies tha	t you are currently taking.							
Name		Dose	Name	Dose						

Are you taking or scheduled to begin any Bisphosphonate Therapy such as Fosamax or Actonel? YES / NO

Since 2001, were you treated or are scheduled to begin treatment with intravenous Bisphosphonates (Aredia or Zometa) for bone pain, hypocalcemia or skeletal complications resulting from Osteoporosis, Paget's Disease, Multiple Myeloma or Metastatic Cancer? YES / NO

Congenital Heart Defect	HEART OR BLOOD DISORDERS			OTHER CONDITIONS			IMMUNE SYSTEM DISORDER		
Heart Murmur	Artificial Heart Valve	Yes	No	Kidney Problems/Dialysis	Yes	No	Systemic Lupus	Yes	No
Angina Yes No Congestive Heart Failure Yes No Cancer Yes No OTHER: Congestive Heart Failure Yes No Cancer	Congenital Heart Defect	Yes	No	Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No
Cancer Yes No Cancer Yes No Cancer Yes No Chemotherapy Yes No Chemotherapy Yes No Radiation Yes No	Heart Murmur	Yes	No	Artificial Joints	Yes	No	Sjogren's Syndrome	Yes	No
Hearl surgery Hearl Attack Yes No Radiation Hearl Attack Yes No Persistent Swollen Glands Yes No Mental Health Disorder Yes No Persistent Swollen Glands Yes No Mental Health Disorder Yes No Descemaker/Defibrillator Yes No Osteoporosis Yes No Anxiety/Panic Attacks Yes No Controlled Substance Use Yes No Type: No Type: No There: N	Angina	Yes	No	Type: Date:			Allergies	Yes	No
Heart Attack Yes No Persistent Swollen Glands Prosthetic Heart Valve Yes No Osteoprosis Yes No Anxiety/Panic Attacks Yes No Corrolled Substance Use Yes No Corrolled	Congestive Heart Failure	Yes	No	Cancer	Yes	No	OTHER:		
Prosthetic Heart Valve Yes No Persistent Swollen Glands Yes No Mental Health Disorder Yes No Dacemaker/Defibrillator Yes No Osteoporosis Yes No Anxiety/Panic Attacks Yes No Bacterial Endocarditis Yes No Chronic Pain Yes No Cortorary Artery Disease Yes No Chronic Pain Yes No Cortorary Artery Disease Yes No Chronic Pain Yes No Chronic Pain Yes No Controlled Substance Use Yes No Cortorary Artery Disease Yes No Date: High Blood Pressure Yes No Due Date: Hemophilia Yes No OTHER: Tobacco Use Yes No OTHER: INFECTIOUS DISEASE AIDS/HIV Yes No OTHER: INFECTIOUS DISEASE AIDS/HIV Yes No OTHER: INFECTIOUS DISEASE History of Tuberculosis Yes No OTHER: Diabetes: Type I Type II Yes No Cough that produces blood Yes No Ucers/Gastritis Yes No OTHER: Persistent cough greater than 3 weeks duration Yes No Gas. Reflux/Heartburn Yes No OTHER: Inflammatory Disease Yes No OTHER: Neurological Disorder Yes No OTHER:	Heart surgery	Yes	No	Chemotherapy	Yes	No			
Pacemaker/Defibrillator Yes No Osteoporosis Yes No Anxiety/Panic Attacks Yes No Bacterial Endocarditis Yes No Chronic Pain Yes No Controlled Substance Use Yes No Coronary Artery Disease Yes No Pergnant Yes No Due Date: Heligh Blood Pressure Yes No Due Date: Hemophilia Yes No No Manual per week: Anemia Yes No OTHER: INFECTIOUS DISEASE AlDS/HIV Yes No Interested in quitting? Yes No OTHER:	Heart Attack	Yes	No	Radiation	Yes	No	BEHAVIORAL CONDITIONS		
Bacterial Endocarditis Yes No Chronic Pain Yes No Controlled Substance Use Yes No Coronary Artery Disease Yes No Pregnant Yes No Due Date: No Due Date: No Due Date: No Type: Alcohol Use Yes No Amount per week: No Amount per day: Interested in quitting? Yes No No OTHER: N	Prosthetic Heart Valve	Yes	No	Persistent Swollen Glands	Yes	No	Mental Health Disorder	Yes	No
Coronary Artery Disease Yes No Pregnant Yes No Due Date:	Pacemaker/Defibrillator	Yes	No	Osteoporosis	Yes	No	Anxiety/Panic Attacks	Yes	No
High Blood Pressure Yes No Due Date: Hemophilia Yes No Nursing Yes No Amount per week: Alcohol Use Yes No Amount per week: Tobacco Use Yes No Interested in quitting? Yes No Interested in quitting? Yes No Interested in quitting? Yes No OTHER: INFECTIOUS DISEASE AIDS/HIV Yes No Interested in quitting? Yes No Interested in quitting? Yes No Active Tuberculosis Yes No OTHER: Hormonitis Yes No OTHER: Hormonal DISORDERS	Bacterial Endocarditis	Yes	No	Chronic Pain	Yes	No	Controlled Substance Use	Yes	No
Hemophilia Yes No Nursing Yes No Amount per week: Anemia Yes No OTHER: INFECTIOUS DISEASE AliDS/HIV Yes No OTHER: Emphysema/COPD Yes No Sexually transmitted disease Yes No OTHER: Bronchitis Yes No OTHER: History of Tuberculosis Yes No GASTROINTESTINAL DISORDERS Persistent cough greater than 3 weeks duration Yes No Ucers/Gastritis Yes No OTHER: Persistent Emphysema of the produces blood Yes No Ucers/Gastritis Yes No OTHER: Been exposed to anyone with Tuberculosis Yes No OTHER: No OTHER: No DIABAGE No GASTROINTESTINAL DISORDERS Persistent cough greater than 3 weeks duration Yes No Ucers/Gastritis Yes No OTHER:	Coronary Artery Disease	Yes	No	Pregnant	Yes	No	Туре:		
Anemia Yes No OTHER: Tobacco Use Yes No OTHER: Type: Amount per day: Interested in quitting? Yes No Interested in quitting? Yes No OTHER: Interest	High Blood Pressure	Yes	No	Due Date:			Alcohol Use	Yes	No
OTHER: RESPIRATORY/LUNG CONDITIONS Asthma Yes No Hepatitis Yes No OTHER: Emphysema/COPD Yes No OTHER: HORMONAL DISORDERS Persistent cough greater than 3 weeks duration Yes No Ulcers/Gastritis Yes No Ulcers/Gastritis Yes No OTHER: Been exposed to anyone with Tuberculosis Yes No OTHER: Inflammatory Disease Yes No OTHER: No OTHER: HORMONAL DISORDERS Yes No OTHER: H	Hemophilia	Yes	No	Nursing	Yes	No	Amount per week:		
INFECTIOUS DISEASE Amount per day: Interested in quitting? Yes No No Interested in quitting? Yes No No Interested in quitting? Yes No No Interested in quitting? Yes No OTHER: Hormonial provided in quitting? Yes No OTHER:	Anemia	Yes	No	OTHER:			Tobacco Use	Yes	No
AIDS/HIV Yes No Interested in quitting? Yes No OTHER: Emphysema/COPD Yes No Sexually transmitted disease Yes No Interested in quitting? Yes No OTHER: Emphysema/COPD Yes No OTHER: History of Tuberculosis Yes No OTHER: HORMONAL DISORDERS Yes No Diabetes: Type I Type II Ty	OTHER:						Туре:		
Asthma Yes No Hepatitis Yes No OTHER: Emphysema/COPD Yes No Sexually transmitted disease Yes No Bronchitis Yes No OTHER: History of Tuberculosis Yes No OTHER: No GASTROINTESTINAL DISORDERS Persistent cough greater than 3 weeks duration Yes No Ulcers/Gastritis Yes No OTHER: Inflammatory Disease Yes No OTHER: NEUROLOGICAL DISORDERS Epilepsy Yes No Migraine Yes No Migraine Migraine OTHER:				INFECTIOUS DISEASE			Amount per day:		
Emphysema/COPD Yes No Sexually transmitted disease Yes No Bronchitis Yes No OTHER: History of Tuberculosis Yes No GASTROINTESTINAL DISORDERS Persistent cough greater than 3 weeks duration Cough that produces blood Yes No Ulcers/Gastritis Yes No OTHER: Inflammatory Disease Yes No OTHER: NEUROLOGICAL DISORDERS No Migraine Yes No OTHER: No MORMONAL DISORDERS Diabetes: Type I Type II Yes No Recent A1C Thyroid Problem Yes No OTHER:	RESPIRATORY/LUNG CONDITIONS			AIDS/HIV	Yes	No	Interested in quitting?	Yes	No
Bronchitis Yes No OTHER: History of Tuberculosis Active Tuberculosis Persistent cough greater than 3 weeks duration Cough that produces blood OTHER: No Eating Disorder Inflammatory Disease Yes No OTHER: No OTHER: No Diabetes: Type I Type II Yes No Recent A1C Thyroid Problem Yes No OTHER: OTHER: No OTHER: No OTHER: No DIABET Type II Yes No Recent A1C Thyroid Problem Yes No OTHER: No O	Asthma	Yes	No	Hepatitis	Yes	No	OTHER:		
History of Tuberculosis Active Tuberculosis Yes No GASTROINTESTINAL DISORDERS Persistent cough greater than 3 weeks duration Yes No G.E. Reflux/Heartburn Yes No Ulcers/Gastritis Yes No OTHER: OTHER: NEUROLOGICAL DISORDERS Epilepsy Yes No Migraine Diabetes: Type I Type II Yes No Recent A1C Thyroid Problem Yes No Thyroid Problem Yes No OTHER: NO OTHER: NO Recent A1C Neurological Disorder Recent A1C Neurological Disorder No OTHER: NO Thyroid Problem Yes No OTHER:	Emphysema/COPD	Yes	No	Sexually transmitted disease	Yes	No			
Active Tuberculosis Yes No DISORDERS Persistent cough greater than 3 weeks duration Yes No G.E. Reflux/Heartburn Yes No Thyroid Problem Yes No Cough that produces blood Yes No Ulcers/Gastritis Yes No OTHER: Been exposed to anyone with Tuberculosis Yes No Eating Disorder Yes No OTHER: Inflammatory Disease Yes No OTHER: New OTHER: Ne	Bronchitis	Yes	No	OTHER:			HORMONAL DISORDERS		
Persistent cough greater than 3 weeks duration Yes No G.E. Reflux/Heartburn Yes No Thyroid Problem Yes No Cough that produces blood Yes No Ulcers/Gastritis Yes No OTHER: Been exposed to anyone with Tuberculosis Yes No Eating Disorder Yes No OTHER: Inflammatory Disease Yes No OTHER:	History of Tuberculosis	Yes	No				Diabetes: Type I Type II	Yes	No
Cough that produces blood Yes No Ulcers/Gastritis Yes No OTHER: Been exposed to anyone with Tuberculosis Yes No Inflammatory Disease Yes No OTHER: OTHER: NEUROLOGICAL DISORDERS Epilepsy Yes No Stroke Yes No Migraine Yes No	Active Tuberculosis	Yes	No				Recent A1C		
Been exposed to anyone with Tuberculosis Yes No Eating Disorder Yes No OTHER: NEUROLOGICAL DISORDERS Epilepsy Yes No Stroke Yes No Migraine Yes No Migraine	Persistent cough greater than 3 weeks duration	Yes	No	G.E. Reflux/Heartburn	Yes	No	• *	Yes	No
OTHER: Inflammatory Disease Yes No OTHER: NEUROLOGICAL DISORDERS Epilepsy Yes No Stroke Yes No Migraine Yes No	Cough that produces blood	Yes	No	Ulcers/Gastritis	Yes	No	OTHER:		
NEUROLOGICAL DISORDERS Epilepsy Stroke Yes No Migraine Yes No	Been exposed to anyone with Tuberculosis	Yes	No	Eating Disorder	Yes	No			
NEUROLOGICAL DISORDERS Epilepsy Stroke Yes No Migraine Yes No	OTHER:			Inflammatory Disease	Yes	No			
Epilepsy Yes No Stroke Yes No Migraine Yes No				OTHER:			1		
Epilepsy Yes No Stroke Yes No Migraine Yes No							1		
Stroke Yes No Migraine Yes No				NEUROLOGICAL DISORDERS			1		
Migraine Yes No				Epilepsy	Yes	No			
, v				Stroke	Yes	No	1		
OTHER:				Migraine	Yes	No	1		
				OTHER:			1		

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT

The undersigned hereby authorizes employees of Family Dental Care of Milford, Prof. Assn. to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapies that may be indicated and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

Patient signature	Date			S	Staff	•					
(Parent or Guardian if Minor)				-							
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