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 Name _____ **Date of Birth** _____

Dental Information

Have you had periodontal treatment?	Yes	No
Do you wear dentures or partials?	Yes	No
Has a Physician or Dentist recommended that you take antibiotics prior to your dental treatment?	Yes	No

Previous Dentist's Name _____ City and State _____

Date of last dental visit _____

Medical Information

Physician's Name _____ City and State _____

Date of last physical exam _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? YES / NO (circle)
Has there been any change in your general health within the past year or are you being treated for a condition now? YES / NO (circle)

If yes, please explain _____

Please circle if you are allergic to the following:

Local Anesthetics Aspirin Penicillin or Other Antibiotics Latex Foods Barbiturates

Sedatives Sulfa Drugs Codeine or Other Narcotics Other _____

Describe Reaction _____

Prescription or Non Prescription or Herbal Medications
List all medications and Herbal Supplements/Remedies that 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

PLEASE COMPLETE BOTH SIDES
Please circle YES or NO for any illness that you CURRENTLY HAVE OR PREVIOUSLY HAD.

HEART OR BLOOD DISORDERS		
Artificial Heart Valve	Yes	No
Congenital Heart Defect	Yes	No
Heart Murmur	Yes	No
Angina	Yes	No
Congestive Heart Failure	Yes	No
Heart surgery	Yes	No
Heart Attack	Yes	No
Prosthetic Heart Valve	Yes	No
Pacemaker/Defibrillator	Yes	No
Bacterial Endocarditis	Yes	No
Coronary Artery Disease	Yes	No
High Blood Pressure	Yes	No
Hemophilia	Yes	No
Anemia	Yes	No
OTHER:		

RESPIRATORY/LUNG CONDITIONS		
Asthma	Yes	No
Emphysema/COPD	Yes	No
Bronchitis	Yes	No
History of Tuberculosis	Yes	No
Active Tuberculosis	Yes	No
Persistent cough greater than 3 weeks duration	Yes	No
Cough that produces blood	Yes	No
Been exposed to anyone with Tuberculosis	Yes	No
OTHER:		

OTHER CONDITIONS		
Kidney Problems/Dialysis	Yes	No
Liver Disease	Yes	No
Artificial Joints	Yes	No
Type: *Date:*		
Cancer	Yes	No
Chemotherapy	Yes	No
Radiation	Yes	No
Persistent Swollen Glands	Yes	No
Osteoporosis	Yes	No
Chronic Pain	Yes	No
Pregnant	Yes	No
Due Date:		
Nursing	Yes	No
OTHER:		

INFECTIOUS DISEASE		
AIDS/HIV	Yes	No
Hepatitis	Yes	No
Sexually transmitted disease	Yes	No
OTHER:		

GASTROINTESTINAL DISORDERS		
G.E. Reflux/Heartburn	Yes	No
Ulcers/Gastritis	Yes	No
Eating Disorder	Yes	No
Inflammatory Disease	Yes	No
OTHER:		

NEUROLOGICAL DISORDERS		
Epilepsy	Yes	No
Stroke	Yes	No
Migraine	Yes	No
OTHER:		

IMMUNE SYSTEM DISORDER		
Systemic Lupus	Yes	No
Rheumatoid Arthritis	Yes	No
Sjogren's Syndrome	Yes	No
Allergies	Yes	No
OTHER:		

BEHAVIORAL CONDITIONS		
Mental Health Disorder	Yes	No
Anxiety/Panic Attacks	Yes	No
Controlled Substance Use	Yes	No
Type:		
Alcohol Use	Yes	No
Amount per week:		
Tobacco Use	Yes	No
Type:		
Amount per day:		
Interested in quitting?	Yes	No
OTHER:		

HORMONAL DISORDERS		
Diabetes: Type I Type II	Yes	No
Recent A1C		
Thyroid Problem	Yes	No
OTHER:		

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 ________ Staff ____________

(Parent or Guardian if Minor)

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