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