Cranford Center for Periodontics & Dental Implants

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Medical

1. Has there been any change in your general health within the past year ◯ Yes ◯ No

2. My last physical examination was on:

_____

_____

3. Are you under the care of a physician ◯ Yes ◯ No

If yes, What is the condition being treated:

_____

_____

4. The name and address of my physician is:

_____

_____

5. Have you had any serious illness within the past 5 years: ◯ Yes ◯ No

If so, what was the illness:

_____

_____

6.Have you been hospitalized or had an operation within the past 5 years: ◯ Yes ◯ No

If so, what was the problem

_____

_____

7. Do you have or have you had any of the following diseases or problems

- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congential heart disease
- ☐ Cardiovascular disease
- ☐ Artificial or replacement valves
- ☐ Pacemaker
- ☐ Allergy
- ☐ Asthma or hay fever
- ☐ Hives or skin rash
- ☐ Fainting spells
- ☐ Seizures
- ☐ Diabetes
- ☐ Hepatitis, jaundice or liver disease
- ☐ Arthritis or inflammatory rheumatism
- ☐ Artificial or replacement joint
- ☐ Digestive system - Ulcers or stomach disorders
- ☐ Kidney troubles
- ☐ Tuberculosis
- ☐ Persistent cough or cough up blood
- ☐ Immune system disorders
- ☐ Venereal disease
- ☐ AIDS or HIV
- ☐ Blood disorder - anemia
- ☐ High Cholestrol
- ☐ High/ Low Blood Pressure

12. Are you taking any of following:

- ☐ Antibiotics or Sulfa drugs
- ☐ Anticoagulants(Blood thinner)
- ☐ Cortisone(steriods)
- ☐ Tranquilizers
- ☐ Anti histamine
- ☐ Aspirin
- ☐ Insulin, tolbutamide or similar drug for diabetes
- ☐ Digitalis or drugs for heart troubles
- ☐ Nitroglycerin
- ☐ Other

If yes to any of the above, state drugname, dosage and frequency

3. Are you allergic or have any reacted adversely to:

☐ Local anesthetics	☐ Penicillin or other antibiotics	☐ Sulfa drugs
☐ Barbiturates, sedatives or sleeping pills	☐ Aspirin	☐ Iodine
☐ Codine or other narcotics	☐ Other	

4. Do you use any tobacco products ◯ Yes ◯ No

If yes, how much per day and what

_____

_____

5. Do you use any alcohol products: ◯ Yes ◯ No

If yes, how much per day/ week/month

_____

_____

6. Do you use any caffeinated products (Coffee, tea. chocolate etc) ◯ Yes ◯ No

If yes, how much per day and what

_____

_____

8. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation: ◯ Yes ◯ No

9. Are you wearing contact lenses: ◯ Yes ◯ No

10. Are you experiencing stress or pressure in your work or at home ◯ Yes ◯ No

WOMEN

1. Are you pregnant ◯ Yes ◯ No

2. Do you have PMS or problems associated with your menstrual period ◯ Yes ◯ No

3. Are you taking birth control or hormone therapy ◯ Yes ◯ No

PHARMACY INFORMATION - Pharmacy name and number where you would like us to call in prescription medicine

Pharmacy name:

_____

_____

Pharmacy Phone number:

_____

_____

Patient Name: _____ * _____ * ____ _____

Last First MI Preferred Name

☐ ***To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or change in my medication, will inform the dentist atte next appointment.**

Response Date: _____