Dental Implants and Periodontal Health of Rochester

1815 South Clinton Ave Suite 510 Rochester, NY Office: 585-685-2005 Fax: 585-685-2003

Health History

Name_____ Date_____

Date of last health care exam_____ Reason for exam _____

Have you been hospitalized in the last five (5) years? (please circle) No Yes

If yes, reason _____

Are you currently receiving medical care? No Yes If yes, nature of care _____

Please list all the names and phone numbers of the dentists and physicians who are providing care for you

1. General Dentist_____
2. Primary Care MD_____
3. Specialist MD_____

Age_____Height_____Weight_____

For the following questions, please circle yes or no. Your answers are for our records only and will be confidential. Please note that our team may ask additional questions concerning your health in order to optimize your care.

Anemia or Blood Disorder	No	Yes	Hepatitis, any form	No	Yes
Diabetes—Type I or Type II Last HbA_1C- date_____ value_____	No	Yes	Liver disease	No	Yes
Asthma Hospitalization required?	No No	Yes Yes	Joint replacement- what joint_____ When placed?	No	Yes
COPD or other lung disease Do you use a Bi-PAP or CPAP?	No No	Yes Yes	HIV infection / AIDS or ARC	No	Yes
Abnormal bleeding	No	Yes	Kidney disease	No	Yes
Epilepsy, seizure, fainting spells	No	Yes	Psychiatric care	No	Yes
Abnormal heartbeat	No	Yes	Stroke	No	Yes
Heart disease, Heart attack, and/or Heart surgery	No	Yes	Cancer or tumor Radiation or Chemotherapy	No	Yes
Heart stent when placed?	No	Yes	Glaucoma	No	Yes
Heart murmur, heart valve disease	No	Yes	Rheumatic fever	No	Yes
Heart and/or valve replacement	No	Yes	Recurrent sinus infections	No	Yes
Previous Bacterial Endocarditis	No	Yes	Slow healing mouth sores	No	Yes
Arthritis, Rheumatism, Inflammatory disease	No	Yes	High blood pressure	No	Yes

Abnormal Blood Pressure? (please circle) No Yes What is your normal blood pressure?: _____
Today (in office): BP_____ HR_____

Are you taking any of these medications?

Pre-medication prior to dental treatment?	No	Yes	Aspirin	No	Yes
Barbiturates	No	Yes	Vitamin E	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Flax, Fish or Krill Oil	No	Yes
Have you ever been treated with Bisphosphonate medication? (Fosamax, Didronel, Aclast, Atelvia, Skelid, Aredia, Zometa, Actonel, Boniva, Reclast, Xgeva, Prolia, Denosumab) If so when did treatment begin? _____ When did treatment end? _____				No	Yes
Anticoagulants? (Warfarin, Coumadin, Rivaroxaban, Xarelto, Pradaxa, Eliquis, Lovenox, Brilinta, Plavix)				No	Yes
Immunosuppressants? (Humira, Remicade, Enbrel)				No	Yes

Medications

Please list any medications (prescription and over-the-counter) you are currently taking; include any medication patches and medications for smoking cessation:

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Please list any dietary or herbal supplements you are taking and for what purpose:

1._____ 2._____
3._____ 4._____
5._____ 6._____

Allergies/Adverse Reactions

Are you allergic or have you had a reaction to:			Type of Reaction
a. Latex or Metals	No	Yes	_____
b. Antibiotics	No	Yes	_____
which? (please circle) Penicillin Sulfa Erythromycin Tetracycline Cipro Azithromycin Clindamycin other_____			_____
c. Aspirin, Ibuprofen, Tylenol	No	Yes	_____
d. Local anesthetics, including topical	No	Yes	_____
e. Codeine, Valium, or other sedatives	No	Yes	_____
f. Sulfites or preservatives	No	Yes	_____
g. Other_____			_____

Women

a. Are you pregnant?	No	Yes
b. Are you a nursing mother?	No	Yes
c. Menopause?	No	Yes

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes circle type: smoke chew vape patch lozenge gum Zyn bidis How much per day? For how many years?	No	Yes
Do you want to quit using tobacco?	No	Yes
Have you used or smoked tobacco in the past? How much? For how many years?	No	Yes
Do you consume alcohol? If yes, approximately how many drinks per week?	No	Yes
Do you use any mood-altering drugs other than those listed previously?	No	Yes

Is there anything else we should know about your health that was not covered by this questionnaire? _____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____
Patient (Print Name) *Patient Signature* *Date*

_____ _____ _____
Doctor (Print Name) *Doctor Signature* *Date*