Emerald Dental

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Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Are you now under the care of a physician? * ◯ Yes ◯ No

If yes, please explain:

_____

_____

Have you had any serious illnesses, or have been hospitalised in the last 5 years? If yes please explain

_____

_____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Premed-Amoxicillin
- ☐ Allergy-Anesthetic
- ☐ Allergy-Cephlasporin
- ☐ Allergy-Entex
- ☐ Allergy-Latex
- ☐ Allergy-NSAIDS
- ☐ Allergy-Penicillin
- ☐ Allergy-Tylenol
- ☐ Arthritis
- ☐ Bleeding-Excessive
- ☐ Blood Thinners
- ☐ Cardiovascular Disea
- ☐ Circulatory Problems
- ☐ Dizziness/Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart- Murmur
- ☐ Heart-CHF
- ☐ Immune Deficiency
- ☐ Mental Disorders
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Respiratory/COPD
- ☐ Seizures
- ☐ Spinal Stenosis
- ☐ Thyroid Condition
- ☐ Vision Loss
- ☐ *Premed-Clindamycin
- ☐ Allergy-Aspirin
- ☐ Allergy-Clindamycin
- ☐ Allergy-Epinephrine
- ☐ Allergy-Levofloxacin
- ☐ Allergy-Naproxin
- ☐ Allergy-Seasonal
- ☐ Allergy-Vicodin
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Blood-Clotting
- ☐ Cerebral palsy
- ☐ Crohns Disease
- ☐ Epilepsy
- ☐ Growths
- ☐ Headaches
- ☐ Heart- Pacemaker
- ☐ Heart-Mitral Valve
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Osteopenia
- ☐ Pre-Diabetic
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ x Other Note Below
- ☐ ADD/ADHD
- ☐ Allergy-Benzodiazapi
- ☐ Allergy-Codeine
- ☐ Allergy-Gluten
- ☐ Allergy-Medication
- ☐ Allergy-Other
- ☐ Allergy-Sulfa
- ☐ Allergy-Warfarin
- ☐ Asthma
- ☐ Blood Pressure-High
- ☐ Brain Surgery
- ☐ Chemotherapy
- ☐ Dental Anxiety
- ☐ Fibromyalgia
- ☐ HIV/AIDS
- ☐ Hearing Loss
- ☐ Heart- Problems
- ☐ Hepatitis
- ☐ Knee Surgery
- ☐ Narcolepsy
- ☐ Osteoporosis
- ☐ Psychiatric care
- ☐ Rheumatism
- ☐ Sleep Apnea
- ☐ TMJ Disorder
- ☐ Tumors
- ☐ Allergy-Amoxicillin
- ☐ Allergy-Cephalexin
- ☐ Allergy-Compazine
- ☐ Allergy-Ibuprofen
- ☐ Allergy-Metronidazol
- ☐ Allergy-Oxycodone
- ☐ Allergy-Toprol
- ☐ Anemia
- ☐ Autism
- ☐ Blood Pressure-Low
- ☐ Cancer
- ☐ Chronic Headaches
- ☐ Diabetes
- ☐ GERD/Ulcers/Reflux
- ☐ Hay Fever
- ☐ Heart- Disease
- ☐ Heart-A-fib
- ☐ Hip Replacement
- ☐ Liver Disease
- ☐ Nervous Conditions
- ☐ Other
- ☐ Radiation Treatment
- ☐ STI's
- ☐ Smoker/Vaper
- ☐ Thallasemia
- ☐ Vertigo

☐ Recent hospitalization (illness or injury)
☐ Presently being treated for any other illnesses/conditions
☐ Tobacco Use- Smoke, Vape or Chew
☐ Alcohol Dependancy
☐ Chemical Dependency
☐ Persistant cough greater then 3 weeks
☐ Cough that produces blood
☐ Been exposed to anyone with Tuberculosis

If any conditions or alerts selected above need further clarification, please describe below:

Women Only:

Please select all the apply:

☐ Currently Pregnant ☐ Currently Nursing ☐ Currently taking Birth Control ☐ Trying to get pregnant(Invitro)
☐ Hormone Replacement Therapy

Bone Density Treatment

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? If yes treatment began

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax?) or risedronate (Actonel?) for osteoporosis or Paget's disease?

◯ Yes ◯ No

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? * ◯ Yes ◯ No

Do you take antibiotic premedication for your dental visits? * ◯ Yes ◯ No

Please explain your need to premedicate: *

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Are you taking or have recently taken prescription or over the counter medication? ◯ Yes ◯ No

If so, please list all including vitamins, herbal, natural and or dietary supplements

Please list any medications you are currently taking, one medication per line:

Physician Name and Phone Number:

Pharmacy Name and Phone Number

Dental History

Previous Dentist Name and Phone Number:

Reason for leaving your previous Dentist? * _____

Date of most recent dental exam and dental x-rays:

When was your last dental cleaning? * _____

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is the reason for your dental visit today?

Is there anything about the appearance of your smile that you would like to change?

Please check all that apply:

- ☐ Gums bleed when you brush or floss
- ☐ Bad mouth odor
- ☐ Have broken fillings
- ☐ Teeth sensitive to cold, hot, sweets or pressure
- ☐ Periodontal(gum) treatment
- ☐ Had any problems associated with previous dental treatment
- ☐ Currently experiencing dental pain or discomfort
- ☐ Have any clicking, popping, or discomfort in the jaw
- ☐ Have/had sores or ulcers in your mouth
- ☐ Have/had a serious injury to your head or mouth
- ☐ Food gets trapped in spaces
- ☐ Have/had loose teeth
- ☐ Missing teeth
- ☐ Experience Dry Mouth
- ☐ Orthodontic treatment(braces)
- ☐ Drink bottled or filtered water
- ☐ Have/had earaches, or neck pain
- ☐ Brux or grind your teeth
- ☐ Wear dentures or partials

Sleep Apnea:

Please check all that apply:

- ☐ Snore Loudly
- ☐ You stop breathing, choke or gasp during your sleep
- ☐ Feel fatigued or sleepy during the daytime
- ☐ Currently use CPAP

If any of the checked boxes need further explanation, please describe:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Response Date: _____