NEWNAN PERIODONTICS AND DENTAL IMPLANTS

ATLANTA Sleep & Wellness

Patient Name: _____

Although dental personnel primarly treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physcians care now? ☐ No ☐ Yes, explain:_____

Have you ever been hopitalized or had a major operation? ☐ No ☐ Yes, explain:_____

Have you had a serious head or neck injury? ☐ No ☐ Yes, explain:_____

Are you taking any medications, pills or drugs? ☐ No ☐ Yes, explain:_____

Do you take, or have you taken, Phen-Fen or Redux? ☐ No ☐ Yes, explain:_____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐ No ☐ Yes, explain:_____

Are you on a special diet? ☐ No ☐ Yes

Do you use tobacco? ☐ No ☐ Yes

Do you use controlled substances? ☐ No ☐ Yes, explain:_____

Women, Are you: ☐ Pregnant/Trying to get Pregnant ☐ Nursing ☐ Taking Oral Contaceptives

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Local Anestetics ☐ Other - If Yes, explain:_____

Please check Yes or No to indicate if you have ever had any of the following. If yes, please explain below:

AIDS/HIV	☐ No ☐ Yes	Excessive Thirst	☐ No ☐ Yes	Mitral Valve Prolapse	☐ No ☐ Yes
Alzheimer's Disease	☐ No ☐ Yes	Fainting Spells/Dizziness	☐ No ☐ Yes	Osteoporosis	☐ No ☐ Yes
Anaphylaxis	☐ No ☐ Yes	Frequent Cough	☐ No ☐ Yes	Pain in Jaw Joints	☐ No ☐ Yes
Anemia	☐ No ☐ Yes	Frequent Diarrhea	☐ No ☐ Yes	Parathyroid Disease	☐ No ☐ Yes
Angina	☐ No ☐ Yes	Frequent Headaches	☐ No ☐ Yes	Psychiatric Care	☐ No ☐ Yes
Arthritis/Gout	☐ No ☐ Yes	Genital Herpes	☐ No ☐ Yes	Radiation Treatments	☐ No ☐ Yes
Artificial Heart Valve	☐ No ☐ Yes	Glacoma	☐ No ☐ Yes	Recent Weight Loss	☐ No ☐ Yes
Artificial Joints	☐ No ☐ Yes	Hay Fever	☐ No ☐ Yes	Renal Dialysis	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	Heart Attack/Failure	☐ No ☐ Yes	Rheumatic Fever	☐ No ☐ Yes
Blood Disease	☐ No ☐ Yes	Heart Murmur	☐ No ☐ Yes	Rheumatism	☐ No ☐ Yes
Blood Transfusion	☐ No ☐ Yes	Heart Pacemaker	☐ No ☐ Yes	Scarlet Fever	☐ No ☐ Yes
Breathing Problems	☐ No ☐ Yes	Heart Trouble/Disease	☐ No ☐ Yes	Shingles	☐ No ☐ Yes
Bruise Easily	☐ No ☐ Yes	Hemophilia	☐ No ☐ Yes	Sickle Cell Disease	☐ No ☐ Yes
Cancer/Tumors	☐ No ☐ Yes	Hepatitis A	☐ No ☐ Yes	Sinus Trouble	☐ No ☐ Yes
Chemotherapy	☐ No ☐ Yes	Hepatitis B or C	☐ No ☐ Yes	Spina Bifida	☐ No ☐ Yes
Chest Pains	☐ No ☐ Yes	Herpes	☐ No ☐ Yes	Stomach/Intestinal Disease	☐ No ☐ Yes
Cold Sores/Fever Blisters	☐ No ☐ Yes	High Blood Pressure	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Congenital Heart Disorder	☐ No ☐ Yes	High Cholesterol	☐ No ☐ Yes	Swelling of Limbs	☐ No ☐ Yes
Convulsions	☐ No ☐ Yes	Hives or Rash	☐ No ☐ Yes	Thyroid Disease	☐ No ☐ Yes
Cortisone Medicine	☐ No ☐ Yes	Hypoglycemia	☐ No ☐ Yes	Tonsilitis	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Irregular Heartbeat	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes
Drug Addiction	☐ No ☐ Yes	Kidney Problems	☐ No ☐ Yes	Tumors or Growths	☐ No ☐ Yes
Easily Winded	☐ No ☐ Yes	Leukemia	☐ No ☐ Yes	Ulcers	☐ No ☐ Yes
Emphysema	☐ No ☐ Yes	Liver Disease	☐ No ☐ Yes	Venereal Disease	☐ No ☐ Yes
Epilepsy or Seizures	☐ No ☐ Yes	Low Blood Pressure	☐ No ☐ Yes	Yellow Janudice	☐ No ☐ Yes
Excessive Bleeding	☐ No ☐ Yes	Lung Disease	☐ No ☐ Yes		

Have you ever had any serious illness not listed above? ☐ No ☐ Yes, explain:_____

Comments:_____

_____

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To the best of my knowledge, the questions on this form have been accuratly answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It's my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X:_____ Date:_____