

Medical History

Please mark (X) your response to indicate if you have or have had any of the following conditions.

<p>Autoimmune HIV/AIDS <input type="checkbox"/>Yes <input type="checkbox"/>No Rheumatoid arthritis <input type="checkbox"/>Yes <input type="checkbox"/>No Lupus <input type="checkbox"/>Yes <input type="checkbox"/>No Hemophilia <input type="checkbox"/>Yes <input type="checkbox"/>No Other autoimmune condition Specify:</p>	<p>Bone Arthritis <input type="checkbox"/>Yes <input type="checkbox"/>No Joint replacement /artificial joint <input type="checkbox"/>Yes <input type="checkbox"/>No Date: Osteoporosis <input type="checkbox"/>Yes <input type="checkbox"/>No Bisphosphonate use <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p>Digestive System Acid reflux <input type="checkbox"/>Yes <input type="checkbox"/>No Ulcers <input type="checkbox"/>Yes <input type="checkbox"/>No Hepatitis <input type="checkbox"/>Yes <input type="checkbox"/>No Celiac disease <input type="checkbox"/>Yes <input type="checkbox"/>No Crohn’s disease <input type="checkbox"/>Yes <input type="checkbox"/>No Ulcerative colitis <input type="checkbox"/>Yes <input type="checkbox"/>No Eating disorder <input type="checkbox"/>Yes <input type="checkbox"/>No Food allergies <input type="checkbox"/>Yes <input type="checkbox"/>No Specify:</p>	<p>Respiratory System Asthma <input type="checkbox"/>Yes <input type="checkbox"/>No COPD <input type="checkbox"/>Yes <input type="checkbox"/>No Emphysema <input type="checkbox"/>Yes <input type="checkbox"/>No Bronchitis <input type="checkbox"/>Yes <input type="checkbox"/>No Tuberculosis <input type="checkbox"/>Yes <input type="checkbox"/>No Sinusitis <input type="checkbox"/>Yes <input type="checkbox"/>No Sleep apnea <input type="checkbox"/>Yes <input type="checkbox"/>No Difficulty breathing when lying down <input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>Ears Hearing impairment <input type="checkbox"/>Yes <input type="checkbox"/>No Vertigo <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p>Genitourinary System Kidney disease <input type="checkbox"/>Yes <input type="checkbox"/>No Excessive urination <input type="checkbox"/>Yes <input type="checkbox"/>No Sexually transmitted infections <input type="checkbox"/>Yes <input type="checkbox"/>No Specify:</p>		
<p>Eyes Glaucoma <input type="checkbox"/>Yes <input type="checkbox"/>No Wears contacts <input type="checkbox"/>Yes <input type="checkbox"/>No</p>			
<p>Endocrine Diabetes <input type="checkbox"/>Yes <input type="checkbox"/>No Type 1 Type 2 Gestational Family History Thyroid problems <input type="checkbox"/>Yes <input type="checkbox"/>No PCOS <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p>Nervous System Seizures/epilepsy <input type="checkbox"/>Yes <input type="checkbox"/>No Stroke <input type="checkbox"/>Yes <input type="checkbox"/>No Dizziness/fainting <input type="checkbox"/>Yes <input type="checkbox"/>No Migraines. <input type="checkbox"/>Yes <input type="checkbox"/>No Sleep disorder. <input type="checkbox"/>Yes <input type="checkbox"/>No Mental illness. <input type="checkbox"/>Yes <input type="checkbox"/>No Specify:</p>	<p>Cardiovascular System Heart murmur <input type="checkbox"/>Yes <input type="checkbox"/>No Artificial heart valve <input type="checkbox"/>Yes <input type="checkbox"/>No Arteriosclerosis <input type="checkbox"/>Yes <input type="checkbox"/>No Congestive heart failure. <input type="checkbox"/>Yes <input type="checkbox"/>No Heart attack <input type="checkbox"/>Yes <input type="checkbox"/>No High blood pressure <input type="checkbox"/>Yes <input type="checkbox"/>No Congenital heart defects <input type="checkbox"/>Yes <input type="checkbox"/>No Pacemaker <input type="checkbox"/>Yes <input type="checkbox"/>No Atrial fibrillation <input type="checkbox"/>Yes <input type="checkbox"/>No Anemia <input type="checkbox"/>Yes <input type="checkbox"/>No Blood transfusion <input type="checkbox"/>Yes <input type="checkbox"/>No Heart surgery <input type="checkbox"/>Yes <input type="checkbox"/>No High cholesterol <input type="checkbox"/>Yes <input type="checkbox"/>No Use of Fen-Phen ® <input type="checkbox"/>Yes <input type="checkbox"/>No Abnormal or excessive bleeding. <input type="checkbox"/>Yes <input type="checkbox"/>No Bruise easily <input type="checkbox"/>Yes <input type="checkbox"/>No Anticoagulant/”blood thinner” use <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	
<p>Women Only – are you Pregnant? <input type="checkbox"/>Yes <input type="checkbox"/>No Due date: Using birth control? <input type="checkbox"/>Yes <input type="checkbox"/>No Nursing? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p>Other Chemotherapy/Radiation/ Cancer treatment <input type="checkbox"/>Yes <input type="checkbox"/>No Organ transplant <input type="checkbox"/>Yes <input type="checkbox"/>No Recreational drug use <input type="checkbox"/>Yes <input type="checkbox"/>No Specify:</p>		
<p>Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/>Yes <input type="checkbox"/>No If yes, please explain:</p>			
<p>Do you have any disease, condition, or problem not listed that we should know about? <input type="checkbox"/>Yes <input type="checkbox"/>No If yes, please explain:</p>			
<p>Is there anything we can do to make your experience with our office more pleasant?</p>			

I give permission to Fay Periodontal Associates to administer medications and anesthetics necessary for proper periodontal and dental care. Permission is also given to share information about my health care and treatment to my referring dentist and insurance company as needed. I understand that I am fully responsible for all charges whether covered, not covered, or denied by insurance as allowable per the insurance provider contract. Payment is due at the time of service unless prior arrangements are made.

The information I have provided is correct to the best of my knowledge. If changes occur (ie. Modification in prescriptions, new diagnoses or surgeries), I will notify Fay Periodontal Associates. I understand the importance of a truthful health history, including medication use, and that my dental team will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Fay Periodontal Associates responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____