Time 8:00 AM | Integrated Dental Arts, PLLC | Date 9/26/2022

2022 Medical Form UPDATED 4.1.2022

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily 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, c could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

PLEASE LIST ALL DOCTORS (include Primary Care Provider):	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications? PLEASE LIST ALL:	◯ Yes ◯ No	If yes
Are you taking any Vitamins, Herbals or Over-the-Counter medication? PLEASE LIST ALL:	◯ Yes ◯ No	If yes
Have you ever taken any bisphosphonate (ex. Boniva) or Antineoplastic medications (ex. Avastin, Nexavar)?	◯ Yes ◯ No	If yes
Do you take Cialis, Viagra or another ED medication? (Important for life threatening emergency)	◯ Yes ◯ No	If yes
Do you use tobacco, marijuana, vapor or chew?	◯ Yes ◯ No	If yes
Do you use controlled substances? Or have a history of substance addiction?	◯ Yes ◯ No	If yes
Are you Pregnant/Trying to get pregnant?	◯ Yes ◯ No	If yes
Do you take oral contraceptives?(PCOS?)	◯ Yes ◯ No	If yes

Are you allergic to any of the following?

☐ Penicillin	☐ Sulfa Drugs	☐ Codeine
☐ Aspirin	☐ Metal/Acrylic	☐ Local Anesthetic

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Hemophillia ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Convulsions ◯ Yes ◯ No	Hepatitis A,B or C ◯ Yes ◯ No	Recent Weight Loss/Gain ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Cortison Medication ◯ Yes ◯ No	Herpes (oral or genital) ◯ Yes ◯ No	Renal Disease ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Diabetes/Prediabetic ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	Hives/Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Stomach/ Intestinal Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting/ Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	
Blood Disorder ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Liver Disease/Jaundice ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Heart Murmer ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Osteoporosis/ Osteopenia ◯ Yes ◯ No	Tumors/Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Trouble/ Disease ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No			Venereal Disease ◯ Yes ◯ No

Any Illnesses not listed above or additional comments:	◯ Yes ◯ No	If yes
If Diabetic: Current A1c	◯ Yes ◯ No	If yes

Oral Health

Do you have or have you experienced any of the following?

History of Gum/Periodontal Disease ◯ Yes ◯ No	Have you been told you snore? ◯ Yes ◯ No	Wear a CPAP or Diagnosed with Obstructiv ◯ Yes ◯ No	History of Gum/Periodontal Surgery ◯ Yes ◯ No
Dry mouth or Bad Breath ◯ Yes ◯ No	Aware of grinding or clenching teeth ◯ Yes ◯ No	Have you ever worn an oral appliance? ◯ Yes ◯ No	Frequent colds, ear or sinus infections ◯ Yes ◯ No
Jaw Joint Pain, Locking or Sounds ◯ Yes ◯ No	TMJ Symptoms ◯ Yes ◯ No	Ear Pressure or Pain ◯ Yes ◯ No	Tinnitus(ringing in the ears) ◯ Yes ◯ No
Frequent Tension Headaches ◯ Yes ◯ No	Difficult to awaken or headaches when aw ◯ Yes ◯ No	Mouth breather, wet pillow in morning ◯ Yes ◯ No	

Signature

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

Signature of Patient, Parent or Guardian:

X Date:_____