CARY PROSTHODONTICS

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Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications 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 physician's care now? YES NO Doctor's Name & Number: _____
Height in inches: _____" Weight: _____ lbs.

Oral Health Information

Is your current oral condition the result of an accident?	**YES**	**NO**
Do you currently (last 60 days) experience joint pain in the jaw?	**YES**	**NO**
Is there clicking when you open or close your mouth completely?	**YES**	**NO**
Do you have restrictions with opening or closing your mouth completely?	**YES**	**NO**
Do you have trouble eating or swallowing due to your dental condition?	**YES**	**NO**
Do you have a diagnosed medical condition that contributes to the condition of your mouth/oral cavity?	**YES**	**NO**
Have you been diagnosed with cyst, tumor, metastatic disease affecting the mouth, or an abscess?	**YES**	**NO**
Do you have an infection that affects the mouth/oral cavity?	**YES**	**NO**
Do you have trouble getting restful sleep?	**YES**	**NO**
Have you been diagnosed with sleep apnea?	**YES**	**NO**

Allergies

Do you have an allergy to any of the following?

Aspirin	**YES**	**NO**	**Ibuprofen**	**YES**	**NO**	**Acetaminophen**	**YES**	**NO**
Codeine	**YES**	**NO**	**Penicillin**	**YES**	**NO**	**Erythromycin**	**YES**	**NO**
Tetracycline	**YES**	**NO**	**Sulfa**	**YES**	**NO**	**Local Anesthetic**	**YES**	**NO**
Fluoride	**YES**	**NO**	**Latex**	**YES**	**NO**	**Metal (Nickel, Gold, Silver, etc.)**	**YES**	**NO**
Acrylic	**YES**	**NO**	**Other: _____**					

Medical History

Have you ever been hospitalized or had a major operation? YES NO Explain: _____
_____
_____

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

Heart Problems or cardiac stent in the last 6 months	**YES**	**NO**	**Liver disease**	**YES**	**NO**
Infective Endocarditis	**YES**	**NO**	**COPD**	**YES**	**NO**
Artificial Heart Valve or repaired heart defect (PFO)	**YES**	**NO**	**High blood pressure**	**YES**	**NO**
Pacemaker or implantable defibrillator	**YES**	**NO**	**Low blood pressure**	**YES**	**NO**
Orthopedic implant or joint replacement	**YES**	**NO**	**Radiation therapy**	**YES**	**NO**
Rheumatic or Scarlet Fever	**YES**	**NO**	**Emotion difficulties**	**YES**	**NO**
Rheumatic disease	**YES**	**NO**	**Psychiatric treatment**	**YES**	**NO**
Stroke (taking blood thinner)	**YES**	**NO**	**Cancer – current**	**YES**	**NO**

Stroke (acute)	YES	NO	Cancer – history	YES	NO
Anemia or other blood disorder	YES	NO	Spinal cord injury	YES	NO
Prolonged bleeding due to slight cut (INR>35)	YES	NO	Severe burn	YES	NO
Emphysema, shortness of breath, Sarcoidosis	YES	NO	Pheochromocytoma	YES	NO
Tuberculosis, Measles, Chicken Pox, Asthma	YES	NO	BMI over 30	YES	NO
Breathing or sleeping problems (sleep apnea, snoring, sinus)	YES	NO	Myasthenia Gravis	YES	NO
Kidney disease (stones)	YES	NO	Hypertension	YES	NO
Tumor or abnormal growth	YES	NO	Jaundice	YES	NO
Chemotherapy or immunosuppressive medication	YES	NO	Hormonal deficiency	YES	NO
Antidepressant medication	YES	NO	Arthritis	YES	NO
Alcohol/recreational drug use	YES	NO	Glaucoma	YES	NO
Alcohol withdrawal syndrome	YES	NO	Contact lenses	YES	NO
Alcohol daily	YES	NO	Head and neck injury	YES	NO
Alcohol weekly	YES	NO	STI/STD/HPV	YES	NO
Alcohol monthly	YES	NO	AIDS/HIV Positive	YES	NO
Malignant Hyperthermia	YES	NO	Alzheimer's Disease	YES	NO
Ischemic Acute Tuberculosis	YES	NO	Anaphylaxis	YES	NO
TIA (Transient Ischemic Attack)	YES	NO	Angina	YES	NO
Allergy or adverse reaction to anesthesia	YES	NO	Blood Disease	YES	NO
Anxiety (needs anesthesia)	YES	NO	Blood Transfusion	YES	NO
Diabetes (If yes, what type: _____)	YES	NO	Bruise Easily	YES	NO
Hepatitis (If yes, what type: _____)	YES	NO	Chest Pains	YES	NO
Thyroid or parathyroid disease or calcium deficiency	YES	NO	Cortisone Medicine	YES	NO
High Cholesterol or taking a statin drug	YES	NO	Excessive Thirst	YES	NO
Stomach or duodenal ulcer	YES	NO	Frequent Cough	YES	NO
Digestive disorder (i.e. celiac disease, gastric reflux)	YES	NO	Frequent Diarrhea	YES	NO
Tonsillitis	YES	NO	Heart Attack/failure	YES	NO
Epilepsy or convulsion (Seizures)	YES	NO	Heart Murmur	YES	NO
Neurologic Disorders (ADD, ADHD, Prion disease)	YES	NO	Heart Trouble/disease	YES	NO
Viral infections and cold sores	YES	NO	Hemophilia	YES	NO
Lumps or swelling in the mouth	YES	NO	Herpes	YES	NO
Hives, skin rash, Hay Fever	YES	NO	Genital Herpes	YES	NO
Congenital Heart Disorder	YES	NO	Hypoglycemia	YES	NO
Fainting spells/dizziness	YES	NO	Irregular Heartbeat	YES	NO
Stomach/Intestinal Disease	YES	NO	Leukemia	YES	NO
Sickle Cell Disease	YES	NO	Lung Disease	YES	NO
Mitral Valve Prolapse	YES	NO	Shingles	YES	NO
Swelling of limbs	YES	NO	Sinus Trouble	YES	NO
Venereal Disease	YES	NO	Spina Bifida	YES	NO
Osteoporosis/osteopenia (i.e. taking bisphosphonates)	YES	NO			
Autoimmune disease (i.e. Rheumatoid Arthritis, Lupus, Scleroderma, Sjogren's)				YES	NO

Treatment

Currently being treated for other illnesses YES NO If yes, please list: _____

Aware of health changes in the last 24 hrs (i.e. fever, chills, cough, diarrhea)				YES	NO
Are you experiencing any of the following:					
Taking drugs for weight management	YES	NO	Pregnant	YES	NO
Taking dietary supplements	YES	NO	Nursing	YES	NO
Using hormonal birth control methods	YES	NO	Unhappy or depressed	YES	NO
Often exhausted or fatigued	YES	NO	Dialysis	YES	NO
Frequent headaches	YES	NO	Prostate disorder	YES	NO
Considered touchy or sensitive	YES	NO			
Consume nicotine (cigarettes, chewing tobacco, smokeless tobacco – vaping)				YES	NO

Medications

Do you take or have you taken any medications for Osteoporosis? YES NO If yes, please list: _____

_____

Are you taking any of the following medications?

Oxycodone	**YES**	**NO**	**Levorphanol**	**YES**	**NO**	**Morphine**	**YES**	**NO**
Methadon	**YES**	**NO**	**Vicodin**	**YES**	**NO**	**Tapentadol**	**YES**	**NO**
Norco	**YES**	**NO**	**Pethidine**	**YES**	**NO**	**Hycet**	**YES**	**NO**
Codeine	**YES**	**NO**	**Lorcet**	**YES**	**NO**	**Demerol**	**YES**	**NO**
Tramadol	**YES**	**NO**	**Hydrocodone**	**YES**	**NO**	**Diazepam**	**YES**	**NO**
Percodan	**YES**	**NO**	**Fentanyl**	**YES**	**NO**	**Laudanum (Opium Tincture)**	**YES**	**NO**
Oxymorphone	**YES**	**NO**	**Hydromorphone**	**YES**	**NO**	**Other Narcotic/Opioid**	**YES**	**NO**

Other Medications YES NO If yes, see list below.

Medication Name and Dosage:	**Reason for Medication:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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 health. It is my responsibility to inform the dental office of any changes in my medical status.

Patient or Guardian's Signature: _____ Date: _____