Time 3:59 PM

Cascade Family _Implant Dentistry

Date 7/9/2024

Medical History - Updated 7/2/24

Patient Name: Birth Date: Date Created:

General

Do you have a primary care physician, or under the care of any physician? ◯ Yes ◯ No If yes

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you taking any medication, pills, or drugs? ◯ Yes ◯ No If yes

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

Are you on a special diet? ◯ Yes ◯ No If yes

Do you use tobacco? ◯ Yes ◯ No If yes

Do you use any controlled substances? ◯ Yes ◯ No If yes

Are you taking any dietary supplements, vitamins? ◯ Yes ◯ No If yes

Women: Are you...

Pregnant/Trying to get pregnant? ◯ Yes ◯ No If yes

Nursing? ◯ Yes ◯ No

Taking oral contraceptives? ◯ Yes ◯ No

Allergies

Are you allergic to any of the following?

☐ Aspirin
☐ Penicillin
☐ Tetracycline
☐ Local Anesthetics
☐ Chlorhexidine (CHX)
☐ Metal
☐ Nuts
☐ Milk
☐ Codeine
☐ Metal
☐ Erythromycin
☐ Sulfa
☐ Fluoride
☐ Iodine
☐ Latex
☐ Fruit
☐ Red dye

Other ☐ If yes

Please list any medications you are taking, with dosages.

Medical History

Do you have, or have you ever had?

Heart problems or Cardiac Stent	◯ Yes ◯ No	History of Infective Endocarditis	◯ Yes ◯ No	Artificial Heart Valve Replacement	◯ Yes ◯ No
Pacemaker	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	High or Low Blood Pressure	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Orthopedic or Soft tissue Implant (e.g j	◯ Yes ◯ No	Anemia or Other Blood Disorder	◯ Yes ◯ No
Prolonged bleeding due to minor trauma	◯ Yes ◯ No	Asthma or Shortness of Breath	◯ Yes ◯ No	Trouble with Hearing or Ear Infections	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	History of Seizures or Epilepsy	◯ Yes ◯ No
Drug Addition	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Kidney Disease	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Radiation Treatment	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Sickle Cell	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Hepatitis (A, B, C)	◯ Yes ◯ No	Sleep Problems	◯ Yes ◯ No	Liver Disease or Jaundice	◯ Yes ◯ No
Vertigo	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Digestive or Eating Disorders	◯ Yes ◯ No
Osteoporosis/Osteopenia	◯ Yes ◯ No	Arthritis or Gout	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Neurologic Disorders	◯ Yes ◯ No	Viral infections	◯ Yes ◯ No	STI/STD/HPV	◯ Yes ◯ No
Psychiatric Treatment	◯ Yes ◯ No	Challenge Concentrating (ADD/ADHD)	◯ Yes ◯ No	Any other health considerations not list	◯ Yes ◯ No
AIDS/HIV Positive	◯ Yes ◯ No				

Any additional Comments?

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.

Signature of Patient, Parent or Guardian:

X Date:_____