VIRUET PERIODONTICS
IMPLANTS - LASER THERAPY

MEDICAL HISTORY FORM

Title _____ First Name _____ Last Name _____ Preferred name _____

Date of Birth _____ Gender Male or Female Are you available for short notice appointments Yes or No

Emergency Contact _____ Telephone number _____ Relationship _____

MEDICAL INFORMATION

Dental professionals primarily treat the area in and around your mouth. Since your mouth is part of your body any medications you are taking as well as your medical history have an important relationship with your dental treatment. Please answer the following questions.

Are you seeing a family physician? If so, please enter name, phone number and date of last visit. _____

_____

Date of last physical exam: _____

Have you recently (in the last two years) been hospitalized or had a major operation? Please explain. _____

_____

Have you ever had a serious head, neck, or back injury? If so, please explain. _____

_____

Please, go over the following section and indicate which of the following you have or have had. If you need to add any further information, please enter it at the end.

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
☐	☐	Alzheimer's Disease/Dementia	☐	☐	Frequent Headaches/Migraines	☐	☐	Radiation Therapy
☐	☐	Anaphylaxis	☐	☐	Glaucoma Type: ____	☐	☐	Rheumatoid Arthritis
☐	☐	Anemia	☐	☐	Head Injuries	☐	☐	Rheumatic Fever
☐	☐	Anxiety	☐	☐	HIV/AIDS	☐	☐	Respiratory Problems
☐	☐	Arthritis/Gout	☐	☐	Hearing Problems	☐	☐	Sinus Problems
☐	☐	Aspirin use	☐	☐	Heartburn	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Heart Defects/Repair	☐	☐	Sickle Cell Diseases
☐	☐	Autoimmune diseases	☐	☐	Heart Attack Date: ____	☐	☐	Stroke/TIA Date:_____
☐	☐	Artificial Heart Valve	☐	☐	Heart Murmur	☐	☐	Tachycardia
☐	☐	Angina Pectoris	☐	☐	Hemophilia	☐	☐	Thyroid Problems
☐	☐	Blood Disorders	☐	☐	Herpes	☐	☐	☐ Hypothyroidism
☐	☐	Blood Thinners	☐	☐	Hepatitis Type: ____	☐	☐	☐ Hyperthyroidism
☐	☐	Blood Transfusions	☐	☐	High Blood Pressure	☐	☐	Tuberculosis
☐	☐	Bruise Easily	☐	☐	High Cholesterol	☐	☐	Tumors
☐	☐	Colitis	☐	☐	Joint replacement	☐	☐	Taken Fen Phen
☐	☐	Cancer	☐	☐	Kidney Problems	☐	☐	Ulcers
☐	☐	Chemotherapy	☐	☐	Leukemia	☐	☐	Venereal Diseases
☐	☐	Depression	☐	☐	Liver Disease	☐	☐	Use of NSAIDs
☐	☐	Diabetes ***Last HbA1C:____***	☐	☐	Low Blood Pressure	☐	☐	Use of Steroids
☐	☐	Dialysis	☐	☐	Nervous Disorders	☐	☐	Dialysis
☐	☐	Dizziness/Fainting	☐	☐	Nasal Allergies/Hay Fever			
☐	☐	Drug Dependence	☐	☐	Organ Transplant			
☐	☐	Emphysema	☐	☐	Osteoporosis			
☐	☐	Excessive Bleeding	☐	☐	Osteoarthritis			
☐	☐	Epilepsy	☐	☐	Psychiatric Disorders			
☐	☐	Endocarditis	☐	☐	Pacemaker Type: _____			

Please enter details or any further information: _____

_____

List all drugs/medications you are currently taking (include non-prescription drugs and herbal supplements):

- If you have more than eight medications, please attach a separate list.
- If you cannot remember all your medications, please request that your physician sends us a complete medications list.

1. **Name** _____ **Dosage** _____
Frequency _____ **Reason** _____
2. **Name** _____ **Dosage** _____
Frequency _____ **Reason** _____
3. **Name** _____ **Dosage** _____
Frequency _____ **Reason** _____
4. **Name** _____ **Dosage** _____
Frequency _____ **Reason** _____
5. **Name** _____ **Dosage** _____
Frequency _____ **Reason** _____
6. **Name** _____ **Dosage** _____
Frequency _____ **Reason** _____
7. **Name** _____ **Dosage** _____
Frequency _____ **Reason** _____
8. **Name** _____ **Dosage** _____
Frequency _____ **Reason** _____

Are you allergic to or have you had a reaction to any of the following items?

Barbiturates, sedatives, sleeping pills	☐Yes	☐No	Sulfa	☐Yes	☐No
Aspirin	☐Yes	☐No	Clindamycin	☐Yes	☐No
Codeine	☐Yes	☐No	Erythromycin	☐Yes	☐No
Latex	☐Yes	☐No	Dental anesthetics	☐Yes	☐No
Metals	☐Yes	☐No	Food:	☐Yes	☐No
Acrylic	☐Yes	☐No	Other:	☐Yes	☐No
Penicillin	☐Yes	☐No			

Do you take any aspirin daily or any other medication to thin your blood (anticoagulants)? ☐Yes ☐No
Have you ever taken or are currently taking any bone strengthening drugs for treatment or prevention of osteoporosis? ☐Yes ☐No
If yes, what is the name of the medication? _____ Administration route: ☐Oral ☐IV

How long have you been taking it or for how long did you take it? _____

PATIENT DISCLOSURE REGARDING BISPHOSPHONATES & DENTAL PROCEDURES:

Patients should know that there is a risk of future complications associated with certain dental procedures if they have been, or are currently taking bisphosphonate medications. These medications can adversely affect the blood supply to bone, thereby reducing its ordinarily excellent capacity to heal. This risk is increased after surgery, especially extractions, implant placement, or other invasive procedures that might cause mild trauma to the bone. Osteonecrosis may result, which is a long-term destruction of the jaw bone that is often very difficult or impossible to eliminate. It is very important to know if you are currently taking or have ever taken these medications: Fosamax (alendronate), Actonel (risedronate), Actonel with Calcium (risedronate with calcium carbonate), Boniva (ibandronate), Zometa or Reclast (zoledronic acid), Aredia (pamidronate), Neridronate, Olpadronate, Didronel (etidronate), Clorodronate, Tiludronate, Prolia,/Xgeva (Denosumab) or any other bisphosphonate or bone antiresorptive medication.

Have you ever taken any of the above mentioned medications? ☐ **Yes** ☐ **No** If so, please indicate which one of the following statements best applies to you:

-I am presently taking the following Bisphophonate or bone antiresorptive medications: _____
Since when? _____
-I have taken the following Bisphophonate or bone antiresorptive medications: _____
For how long? _____

If you have ever been advised against taking any type of medication, please list them: _____

_____

Have you ever had any joint replacement surgery? ☐Yes ☐No

If yes, please indicate the type and date of the surgery _____

Have you been told by your physician that you need to take premedication (antibiotics) one hour prior to dental appointment? ☐ Yes ☐ No

If yes, please indicate:

Name of antibiotic _____ Dosage _____ Amount _____ Reason for prescription _____

If female, please answer the following:

-Are you taking birth control pills? ☐ Yes ☐ No

-Are you pregnant: ☐ Yes ☐ No If yes, # of weeks:

_____ -Are you nursing? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How many cigarettes per day: _____ Number of years _____

Do you use smokeless tobacco? ☐Yes ☐No How many times per day: _____ Number of years _____

Are you wearing a nicotine patch? ☐Yes ☐No **If you quit smoking, how long ago? _____**

Do you drink alcoholic beverages? ☐ Yes ☐ No How many drinks per day: _____ Number of years

_____ **Do you use any illicit drugs?** ☐ Yes ☐ No

Do you suffer from Sleep Apnea or do you use a C-PAP machine? ☐Yes ☐No

Do you wear eyeglasses or contact lenses? ☐Yes ☐No

Have you traveled out of the country in the past 21 days? ☐ Yes ☐No

In case of an emergency that requires hospitalization, do you consent to blood transfusions? ☐ Yes ☐No

Are you vegan? ☐Yes ☐No

If yes, are there any materials you would prefer we do not use during your surgeries? Ex. Animal products? _____

Due to religious or personal reasons, are there any materials you would prefer we do not use during your surgeries? (Ex. Animal products from bovine or porcine origins). ☐ Yes ☐No

If yes, please specified what materials you would like us to not use: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or her staff responsible for any errors or omissions that I may have made in completion of this form. I accept full financial responsibility for all services rendered.

Patient Signature: _____ Date: _____

(If under 18, Parent or Guardian Signature required)

Reviewed by: _____