DeLand Implant Dentistry

Dr. Jayraj Patel, DMD

150 McGregor Road, Deland, FL 32720/Tel. 386.738.2006 / Fax 386.738.2007/ www.delandimplants.com

Medical History Update

Patient Name: _____ **Phone: Home:** _____
Address: _____ **Work:** _____
City: _____ **State:** _____ **ZIP:** _____ **Cell:** _____
E-mail address: _____
Your preference for contact would be: ____Home ____ Cell ____ Email_____ Text

1. Has there been any change in your health since your last appointment? __Yes __No
For what conditions? _____
2. Do you have any allergies (or adverse reactions) to any medications? __Yes __ No
If so, what _____
3. Are you aware of jaw joint sound? ___ Yes ___ No
4. Did you ever have jaw joint sound? ___ Yes ___ No
5. Do you ever have pain or soreness in front of your ears? ___ Yes ___ No
6. Do you have ear pain? ___ Yes ___ No
7. Do you wake up with your jaws sore or tired? ___ Yes ___ No
8. Do you ever have difficulty opening your jaw widely? ___ Yes ___ No
9. Do you avoid eating certain foods because of pain or discomfort? ___ Yes ___ No
10. Do you snore? ___ Yes ___ No
11. Has anyone reported that you choke or gasp for air while sleeping? ___ Yes ___ No
12. Do you wake up refreshed? ___ Yes ___ No
13. Are you excessively tired during the day? ___ Yes ___No
14. Do you have high blood pressure? ___ Yes ___ No
15. Do you have any other concern with your teeth or gums:___ Yes ___ No

If yes, explain: _____

List all medications you are taking (or supposed to take) including over the counter medications, aspirin, birth control pills or hormones (if none, so state):

Medication - Dosage - Time / Day

_____
_____
_____
_____
_____
_____
_____

Patient's Signature: _____ **Date:** _____

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Patient Name: _____ **Date of Birth:** _____

Medical History

Please indicate the appropriate answer if you have / had any of the following

Heart / Cardiovascular

1. ___ Yes ___No: Rheumatic Heart Disease / heart murmur
2. ___ Yes ___No: Damaged or Artificial heart valve
3. ___ Yes ___No: Mitral valve prolapse
4. ___ Yes ___No: Congenital heart disease
5. ___ Yes ___No: High blood pressure
6. ___ Yes ___No: Low blood pressure
7. ___ Yes ___No: Arteriosclerosis / High cholesterol
8. ___ Yes ___No: Chest pain after exertion
9. ___ Yes ___No: Shortness of breath after mild exercise
10. ___ Yes ___No: Heart attack
11. ___ Yes ___No: bypass surgery
12. ___ Yes ___No: Heart pace maker/Irregular or rapid Heart rate
13. ___ Yes ___No: Stroke
14. ___ Yes ___No: Do your ankles swell?
15. ___ Yes ___No: Do you use extra pillows to sleep?
16. ___ Yes ___No: Other heart problems?

Allergies To:

1. ___ Yes ___No: Penicillin
2. ___ Yes ___No: Sulfa
3. ___ Yes ___No: Aspirin / Codeine / Other pain medications _____
4. ___ Yes ___No: Iodine
5. ___ Yes ___No: Sedatives / Sleeping Pills / Barbiturates
6. ___ Yes ___No: Local Anesthetics

   _____
7. ___ Yes ___No: Latex
8. ___ Yes ___No: Metals

   _____
9. Other Medications: -

   _____

   _____

Breathing / Lungs / Sinuses

1. ___ Yes ___No: Shortness of breath / Breathing problem
2. ___ Yes ___No: Asthma / Hay fever
3. ___ Yes ___No: Emphysema / COPD
4. ___ Yes ___No: Tuberculosis / Persistent cough or cold
5. ___ Yes ___No: Sinus problem / Sinusitis /Nasal problem
6. ___ Yes ___No: Do you smoke?

Central Nervous System

1. ___ Yes ___No: Epilepsy
2. ___ Yes ___No: Fainting Spell
3. ___ Yes ___No: Seizures
4. ___ Yes ___No: Emotional disturbances

Blood Conditions

1. ___ Yes ___No: Anemia
2. ___ Yes ___No: Leukemia
3. ___ Yes ___No: Sickle Cell trait / Disease
4. ___ Yes ___No: Hemophilia/Excessive bleeding/Bruise easily
5. ___ Yes ___No: Blood transfusion
6. ___ Yes ___No: HIV positive
7. ___ Yes ___No: Family history of blood disorder

Endocrine System

1. ___ Yes ___No: Do you have Diabetes?
2. ___ Yes ___No: Does anyone in your family have Diabetes?
3. ___ Yes ___No: Hypothyroidism / Hyperthyroidism
4. ___ Yes ___No: Are you thirsty very often / Have a dry mouth?

Digestive System

1. ___ Yes ___No: Stomach ulcers
2. ___ Yes ___No: Hepatitis
3. ___ Yes ___No: Jaundice
4. ___ Yes ___No: Liver Disease

Bones and Joints

1. ___ Yes ___No: Arthritis
2. ___ Yes ___No: Inflammatory Rheumatism
3. ___ Yes ___No: Bone infection
4. ___ Yes ___No: Artificial joints
5. ___ Yes ___No: Osteoporosis

Other

1. ___ Yes ___No: Kidney trouble
2. ___ Yes ___No: Dialysis
3. ___ Yes ___No: Syphilis / Gonorrhea
4. ___ Yes ___No: Lupus / Auto Immune Disease
5. ___ Yes ___No: Do you have glaucoma?
   If yes, what type: Narrow angle:_____ Open angle:_____

Neoplasm

1. ___ Yes ___No: Cancer / Tumor
   If yes, what kind?

   _____
2. ___ Yes ___No: Chemotherapy
   If yes, what medications?

   _____
3. ___ Yes ___No: Radiation Therapy
   If yes, area of radiation: _____

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Medical History (cont.)

General

1. ___ Yes ___No: Do you have or have you ever had any condition, disease, or problem NOT listed above that you think I should know about?
   If yes, explain:
   _____
2. ___ Yes ___No: Do you Drink Alcohol?
   If yes, how much and how often?
   _____
3. ___ Yes ___No: Do you smoke?
   If yes, how much?
   _____
4. ___ Yes ___No: Do you use oral tobacco?
   If yes, how much and how often?
   _____
5. ___ Yes ___No: Do you use any recreational drugs?
   If yes, what and how often?
   _____

Women Only

1. ___ Yes ___No: Are you pregnant or suspect being pregnant?
2. ___ Yes ___No: Are you nursing?
3. ___ Yes ___No: Are you taking any oral contraception or hormonal therapy?
4. ___ Yes ___No: Osteoporosis

Man only:

1. ___ Yes ___ No: Do you use any medication for Eractile Dysfunction?
   If yes, what and when was the last time you used it?
   _____

Dentist's Notes

VITAL SIGNS

B.P.:_____ H.R. : _____ Resp Rate : _____

Weight: _____ Temp :_____

AUTHORIZATION

I understand that the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all the questions to the best of my knowledge. I will not hold Dr. Patel or any other member of his staff responsible for any error or omissions that I might have made in the completion of these forms. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify Dr. Patel of any change in my health or medications. I also consent to the performing of oral and dental exams including any radiographs and any dental treatment and procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated. I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions such as redness and swelling of tissue, pain, itching, vomiting and/or anaphylactic shock.

_____ _____

Patient's/Guardian's Signature **Date**