DUCOIN CENTER FOR ADVANCED DENTISTRY **FDUCOINDMD.COM**
808 SE OCEAN BLVD., STUART, FL 34994 **772-287-6159**

Dental professionals primarily treat conditions in and around your mouth, however your mouth is the gateway to your body. Health issues you may have and/or medications you may be taking, could have an important effect on the dental care you need. We appreciate you assistance in your oral health care by carefully and completely filling in this form If you don't understand a question, consult your dentist. All information is confidential.

Medical History

Patient's Name: Chart No.: Date:

Yes No

❑ ❑ 1. Are you under the care of a physician? If so, for what condition:

❑ ❑ 2. Have you been hospitalized or had a serious illness within the last 3 years? If so, what was the reason:

❑ ❑ 3. Date of your last physical examination:_____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

CARDIOVASCULAR:

❍ Yes ❍ NO Rheumatic Fever
❍ Yes ❍ NO Congenital Heart Defect
❍ Yes ❍ NO Angina
❍ Yes ❍ NO Heart Attack: Date_____
❍ Yes ❍ NO Stroke (CVA)
❍ Yes ❍ NO Heart Valve Replacement: Date:_____
❍ Yes ❍ NO Hypertension (high blood pressure) – b.p._____/_____
❍ Yes ❍ NO Hypotension (low blood pressure) – b.p. _____/_____
❍ Yes ❍ NO Congestive Heart Failure
❍ Yes ❍ NO Heart Surgery Type:_____ Date:_____
❍ Yes ❍ NO Pacemaker Implanted: Date:_____
❍ Yes ❍ NO Arrhythmia
❍ Yes ❍ NO Heart Murmur

RESPIRATORY DISEASES

❍ Yes ❍ NO Asthma
❍ Yes ❍ NO Bronchitis
❍ Yes ❍ NO Emphysema
❍ Yes ❍ NO Hay Fever or Sinusitis

ENDOCRINE DISORDERS

❍ Yes ❍ NO Hyperthyroidism (high thyroid)
❍ Yes ❍ NO Diabetes – Type/Control _____/_____
❍ Yes ❍ NO Hypothyroidism (low thyroid)

BLOOD DISORDERS

❍ Yes ❍ NO Anemia – Type:_____
❍ Yes ❍ NO Bleeding Tendency – do you bruise easily or bleed excessively when cut?

PSYCHIATRIC

❍ Yes ❍ NO Are you presently seeing or have you seen a psychiatrist in the last 3 years?
Physician_____ Telephone_____

INFECTIOUS DISEASES

❍ Yes ❍ NO Hepatitis – Type:_____
❍ Yes ❍ NO Tuberculosis – Date_____
❍ Yes ❍ NO Venereal Disease – Type:_____
❍ Yes ❍ NO HIV Positive
❍ Yes ❍ NO Foreign travel to a country on the CDC Level 3 Travel Warnings List in past year

KIDNEY DISEASE

❍ Yes ❍ NO Kidney surgery?
❍ Yes ❍ NO Kidney infections within the last 3 years?

MISCELLANEOUS DISEASES OR DISORDERS

❍ Yes ❍ NO Artificial Joints - Type _____ Date:_____
If Yes, is Pre-Med indicated ❍ Yes ❍ NO; Type _____
❍ Yes ❍ NO Radiation Therapy – Type_____Date_____
❍ Yes ❍ NO Have you had cancer – Type _____Date_____
❍ Yes ❍ NO Do you use tobacco? – Type_____
❍ Yes ❍ NO Do you drink alcohol? How often?_____
❍ Yes ❍ NO Fainting - Frequency _____
❍ Yes ❍ NO Arthritis – Type _____
❍ Yes ❍ NO Glaucoma
❍ Yes ❍ NO Liver Disease – Type_____
❍ Yes ❍ NO Ulcers – Type _____
❍ Yes ❍ NO Epilepsy – Treatment _____

(PLEASE COMPLETE REVERSE SIDE)

WOMEN ONLY

❍ Yes ❍ NO Pregnant/Trying to get pregnant? Scheduled delivery_____
❍ Yes ❍ NO Nursing ❍ Yes ❍ NO Menstrual difficulty?
❍ Yes ❍ NO Taking Oral Contraceptives?

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

❍ Yes ❍ NO Antibiotics (etc.) Type_____ Amount_____
❍ Yes ❍ NO Blood Thinners (including supplements) Type_____ Amount_____
❍ Yes ❍ NO Steroids Type_____Amount_____
❍ Yes ❍ NO High Blood Pressure Meds Type_____Amount_____
❍ Yes ❍ NO Tranquilizers Type_____ Amount_____
❍ Yes ❍ NO Aspirin – Amount_____ Frequency_____
❍ Yes ❍ NO Chemotherapy _____
❍ Yes ❍ NO **Bone Density Medications** (bisphosphonates) such as Flosamax, Boniva, Actonel, Zometa, Aredina, etc., in the past 12 years?

Others: Drug Amount How Often

_____ _____ _____
_____ _____ _____
❍ LIST ATTACHED

DO YOU HAVE AN ALLERGY OR REACTION TO:

❍ Yes ❍ NO Penicillin or antibiotics – Type_____ Reaction_____
❍ Yes ❍ NO Latex
❍ Yes ❍ NO Sulfa Drugs
❍ Yes ❍ NO Aspirin – Reaction_____
❍ Yes ❍ NO Barbiturates or Sedatives – Type_____Reaction_____
❍ Yes ❍ NO Reaction to local anesthetics
❍ Yes ❍ NO Other Drugs_____Reaction_____

PAST DENTAL HISTORY:

❍ Yes ❍ NO Have you had dental emergencies in the past?
❍ Yes ❍ NO Have you had difficulty with any dental treatment including extractions?
❍ Yes ❍ NO Do you clench or grind your teeth during the day or during the night?
❍ Yes ❍ NO Do you ever wake up with an awareness of your teeth or jaw?
❍ Yes ❍ NO Do you have chronic headaches, or neck and shoulder pains
❍ Yes ❍ NO Do you have any awareness in the muscles of your neck or shoulders?
❍ Yes ❍ NO Do you have pain in your jaw joint or the sides of your face near the ears?
❍ Yes ❍ NO Have you ever experienced a clicking jaw joint or an inability to move or open your mouth widely?

❍ Yes ❍ NO Do you have any problem or condition not listed above?
If so, explain_____
❍ Yes ❍ NO Do you wish to speak to the Doctor privately about anything?

I certify that I have read and understand the questions above, I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

_____ _____ _____
Signature of patient (Parent or Guardian if Minor) Reviewed By Date

I authorize my doctor and legally qualified auxiliaries to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. I authorize taking of all x-rays requires as a necessary part of this examination and acquiring my prior dental records and x-rays if needed for diagnosis. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

_____ _____ _____ _____
Signature of patient (Parent or Guardian if Minor) Witness Doctor Date

HEALTH HISTORY / CONSENT

HEALTH HISTORY / CONSENT