Silvestri and Comfort Digital MedHx Form 1/2017(Update with Premed)

Patient Name: Birth Date: Date Created:

Although your dentist and hygienist primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or m may be taking, could have an important interrelationship with the dentistry you will receive. Please answer these questions honestly and completely, for your safety and th

General Questions

Question	Answer	If yes
Who is your Physician?	○ Yes ○ No	If yes
What is your Physicians office number?	○ Yes ○ No	If yes
What is your preferred pharmacy?	☐	If yes
Are you currently taking any prescription or over the counter medications? Please lsit below.	○ Yes ○ No	
Are you currently taking any Blood Thinners? (Ex: Coumadin, Xarelto, Aspirin, Fish Oil)	○ Yes ○ No	If yes
Do You Premedicate for Dental Treatment?	○ Yes ○ No	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Penicillin/Other Antibiotics ☐ Iodine ☐ Codeine/Other Narcotics ☐ Latex
☐ Sedatives ☐ Metals ☐ Sulfa Drugs ☐ Aspirin
☐ Local Anesthetic

Question	Answer	If yes
Do you have any other allergies/sensitivities?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	○ Yes ○ No	Anaphylaxis	○ Yes ○ No	Anemia	○ Yes ○ No	Chest Pain	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Asthma	○ Yes ○ No	Blood Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Bruise Easily	○ Yes ○ No	Cancer	○ Yes ○ No	Chemotherapy	○ Yes ○ No
Cold Sores/Blisters	○ Yes ○ No	Heart Disorder	○ Yes ○ No	Diabetes	○ Yes ○ No	Drug Addiction	○ Yes ○ No
Emphysema	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Fainting/Dizziness	○ Yes ○ No
Glaucoma	○ Yes ○ No	Hay Fever	○ Yes ○ No	Heart Attack	○ Yes ○ No	Heart Murmur	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Hemophilia	○ Yes ○ No	Hepatitis A, B or C	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Kidney Problems	○ Yes ○ No
Liver Disease	○ Yes ○ No	Lung Disease	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Pain in Jaw Joints	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Rheumatism	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Stomach/Intestinal Disorders	○ Yes ○ No	Stroke	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Tuberulosis	○ Yes ○ No	Tumors or Growths	○ Yes ○ No	Ulcers	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Blood Thinners	○ Yes ○ No	Artificial Joint	○ Yes ○ No				

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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

Signature of Patient, Parent or Guardian:

X Date:__________