DeJesus Dental Group
COSMETIC, FAMILY & IMPLANT DENTISTRY

Patients Name _____ Date of Birth_____

PLEASE CHECK THE APPROPRIATE ANSWER

1. Physician's Name_____
   Address_____
   Phone_____
2. Are you under a physician's care? ☐ YES ☐ NO
   Since when?_____Why?_____
3. When was your last physical exam?_____
4. Are you taking any medications or substances?..... ☐ YES ☐ NO
   (If yes, please list medications in the comments section or on the back of this form)
5. Do you take health related substances? (Vitamins, herbal supplements, etc)…….. ☐ YES ☐ NO
6. Are you allergic to any medications or substances? (please list)…… ☐ YES ☐ NO
7. Do you have any other allergies or hives?..... ☐ YES ☐ NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ☐ YES ☐ NO
9. Are you sensitive to any metals or latex?..... ☐ YES ☐ NO
10. Are you pregnant or suspect to be?..... ☐ YES ☐ NO
11. Do you use any birth control medications?..... ☐ YES ☐ NO
12. Have you ever been treated or been told you might have heart disease?..…….. ☐ YES ☐ NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?
    ……. ☐ YES ☐ NO
14. Have you ever had rheumatic fever?..... ☐ YES ☐ NO
15. Are you aware of any heart murmurs?..... ☐ YES ☐ NO
16. Do you have high or low blood pressure?(please circle) …….. ☐ YES ☐ NO
17. Have you ever had any serious illness or major surgery?..... ☐ YES ☐ NO
    If so, explain_____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ☐ YES ☐ NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment for bone tumors,
    excessive calcium in your blood or ostheoporisis?..... ☐ YES ☐ NO
20. Do you have an inflammatory diseases, such as arthritis or rheumatism?..... …. ☐ YES ☐ NO
21. Do you have any artificial joints/prosthesis?..... …. ☐ YES ☐ NO
22. Do you have any blood disorders, such as anemia, leukemia, etc?..... ☐ YES ☐ NO
23. Have you ever bleed excessively after being cut or injured?..... ☐ YES ☐ NO
24. Do you have any stomach problems?..... ☐ YES ☐ NO
25. Do you have any kidney problems?..... ☐ YES ☐ NO
26. Do you have any liver problems?..... ☐ YES ☐ NO
27. Are you diabetic?..... ☐ YES ☐ NO
28. Do you have fainting or dizzy spells?..... ☐ YES ☐ NO
29. Do you have asthma?..... ☐ YES ☐ NO
30. Do you have epilepsy or seizure disorders?..... ☐ YES ☐ NO
31. Do you or have you had venereal or sexually transmitted disease?..... ☐ YES ☐ NO
32. Have you tested HIV positive?..... ☐ YES ☐ NO
33. Do you have AIDS?..... ☐ YES ☐ NO
34. Have you had or do you test positive for hepatitis?..... ☐ YES ☐ NO
35. Do you or have you had T.B.?..... ☐ YES ☐ NO
36. Do you smoke, chew, use snuff or any other form of tobacco?..... ☐ YES ☐ NO
37. Do you regularly consume more than one or two alcoholic beverages per day?..... ☐ YES ☐ NO
38. Do you habitually use controlled substances?..... ☐ YES ☐ NO
39. Have you had psychiatric treatment?..... ☐ YES ☐ NO
40. Have you taken any prescription drugs fenfluramine, fenfluramin combined with phentermine (fen-phen),
    dexfenfluramine (redux), or other weight loss products?..... ☐ YES ☐ NO
41. Do you have any disease condition, or problem not listed? If so, explain_____
    _____
42. Is there anything else we should know about your health that we have not covered in this form? _____
    _____
43. Would you like to speak to the Doctor privately about the problem?..... ☐ YES ☐ NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE_____DATE_____

DENTIST'S SIGNATURE_____DATE_____

COMMENTS

Clear Form

MEDICAL HISTORY