Contemporary Implantology, Inc. — Health History

Patient Name:		Date of Birth:
Physician Name:	Physician Phone #:	Date of last visit with physician:

Please circle yes or no

Are you currently under the care of your physician? YES NO
If yes, explain:

Are you currently in dental pain, if yes what area? YES NO					
Date of your last dental visit and what treatment was performed?					
What is the reason for your visit today?					
Have you ever had a serious/difficult problem with any previous dental work, if yes what? YES NO					
Have you ever had gum treatment, if yes what and when? YES NO					
Do your gums bleed?	YES	NO	Do you have any loose teeth?	YES	NO
Do you brush and floss daily?	YES	NO	Do you have your wisdom teeth?	YES	NO
Do you have dry mouth?	YES	NO	Are your teeth sensitive to cold or heat?	YES	NO

Are you currently taking medications of any kind, if yes list names and dosage? YES NO
Prescription:
Non-prescription:

Have you been hospitalized in the past 3 years, if yes please explain? YES NO

Are you allergic to any medications, if yes please list name and reaction? YES NO
Are you allergic to (**please circle**)? ASPIRIN CODEINE DENTAL ANESTHETICS E-MYCIN LATEX METALS PENICILLIN TETRACYCLINE

Have you previously had or currently have any of the following? (**please circle**)
MITRAL VALVE PROLAPSE HEART MURMUR JOINT REPLACEMENT HEART VALVE REPLACEMENT RHEUMATIC FEVER
Do you need antibiotic pre-medication before dental treatment, if yes what?

Have you taken any of these medications in the last 6 months, if yes **please place a "√" mark in front of item and list drug name**?	
Cortisone or other steroids:	Anticoagulants or blood thinners:
Tranquilizers or antidepressants:	Nitroglycerine or thyroid extract:
Fosamax or any other bisphosphonate:	

Have you previously had or currently have any of the following conditions? (**please place a "√" mark in front of item if yes**)				
Abnormal Bleeding	Colitis	Glaucoma	Lupus	MS
AIDS / HIV	Congenital Heart Defect	Hay Fever/Allergies	Pace Maker	Thyroid Problems
Anemia	Diabetes	Heart Attack/Surgery	Psychiatric Problems	Tuberculosis (TB)
Angina	Difficulty Breathing	Hepatitis	Radiation Treatment	TMJ pain
Arthritis	Emphysema	Herpes/Fever Blisters	Seizures	Ulcers
Artificial Bones/Joints	Epilepsy	High Blood Pressure	Shingles	Venereal Disease
Asthma	Excessive Bleeding	Kidney Problems	Sickle Cell Disease	
Blood Transfusion	Fainting Spells	Liver Disease	Sinus Problems	
Cancer/Chemo	Frequent Headaches	Low Blood Pressure	Stroke	

Tobacco use? YES NO *Smoke:* Pipe Cigar Cigarettes *Smokeless:* Type: Frequency:
Alcohol use? YES NO *Amount:* Minimal Moderate Heavy
Women: Are you pregnant? YES NO Are you nursing? YES NO

PATIENT OR GUARDIAN SIGNATURE________________________ **DATE**__________