DR VIRAL I PATEL

BDS MDS [PERIODONTOLOGY]

REG NO:- A-1650

Personal Information & History

MEDICAL STATUS FORM

Name Of Patient : _____

Address: _____
_____

Birth date _____ Sex ___M ___F

Phones:

home: _____ work: _____ Mobile:_____

email: _____

The dentistry you receive has an important interrelationship with the health problems that you may have, or medications you are taking. It is imperative that you provide the following information to help us treat you as effectively and safely as possible.

Please initial that you read this paragraph: _____

Are you under a physician's care now?	( )yes ( )no
Have you ever been hospitalized or had a major operation in the past?	( )yes ( )no
Have you ever had a serious head or neck injury?	( )yes ( )no
Are you taking any prescription or non- prescription medications,▫pills, herbal supplements, aspirin, ibuprophen, vitamin E or drugs?	( )yes ( )no
Are you taking or have you taken bisphosphonate for osteoporosis	( )yes ( )no
Have you ever been advised to take pre-medication for dental visits?	( )yes ( )no
Have you ever had a lesion biopsied or removed from the mouth or lips?	( )yes ( )no
Are you on a special diet?	( )yes ( )no
Do you smoke or use tobacco?	( )yes ( )no
Do you use controlled substances?	( )yes ( )no

Do you consume alcohol?	( )yes ( )no
Has anyone told you that you snore?	( )yes ( )no

WOMEN: Are you pregnant or trying to get pregnant? ( ) Yes ( ) No

Taking oral contraceptives? ( ) Yes ( ) No

Nursing? ( ) Yes ( ) No

Are you allergic to any of the following:▫☐Aspirin ☐Penicillin ☐Tetracycline ☐Erythromycin

☐ Acrylic ☐ Metal ☐ Sulfa ☐ Local Anesthetics
☐Other:_____ ▫ No Known Allergies

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

	Asthma	Diabetes	Frequent Headaches	☐yes ☐no	Low Blood		
AIDS/HIV Positive	Blood Disease	☐yes ☐no Drug Addiction	Glaucoma	☐yes ☐no	Implants-Hip/Breast/knee/tooth	☐yes ☐no	Lung Dise
Allergies	Blood Transfusion	☐yes ☐no Eating Disorder (Bulimia or Anorexia)	Heart Attack/Failure	☐yes ☐no	HPV (Human Papilloma Virus)	☐yes ☐no	Mitral Va
Alzheimer's Disease	Bruise Easily	☐yes ☐no Emphysema	Heart Murmur	☐yes ☐no	High Blood Pressure	☐yes ☐no	Osteopo
Anaphylaxis	Cancer	☐yes ☐no Epilepsy or Seizures	Heart Pace Maker	☐yes ☐no	Hives or Rash	☐yes ☐no	Periodon
Anemia	Chemotherapy	☐yes ☐no Excessive Bleeding	Heart Trouble/Disease	☐yes ☐no	Hypoglycemia	☐yes ☐no	Psychiatr
Angina/Chest Pains	Celiac Disease	☐yes ☐no Excessive Thirst	Hemophilia	☐yes ☐no	Irregular Heartbeat	☐yes ☐no	Radiation
Arthritis/Gout	Congenital Heart Disorder	☐yes ☐no Fainting Spells/Dizziness	Hepatitis A, B, C, D, or E	☐yes ☐no	Kidney Problems	☐yes ☐no	Recent W
Artificial Heart Valve	Convulsions	☐yes ☐no Frequent Cough	☐yes ☐no		Leukemia	☐yes ☐no	Renal Dis
Artificial Joint	Cortisone Medicine	☐yes ☐no Frequent Diarrhea	☐yes ☐no		Liver Disease	☐yes ☐no	Rheumat

Have you ever had any serious illness not listed above? ( ) Yes ( ) No▫If yes, please explain: _____▫

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 _____
date_____