Christine J. Coke, DDS, MD, PA
Oral, Facial, and Dental Implant Surgery

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the facial care that you will be receiving. Thank you for answering all of the following questions. Your answers are for our records only, and will be considered confidential. THANK YOU!

Reason for today's visit:_____

Do you consider you reason for your visit to be: Medical or Dental

If medical, were you referred by your primary care physician? YES NO

Who is your primary care physician?_____

Who is your primary dentist? _____

Do you have a referral letter? YES NO

How were you referred to us?_____

Whom may we thank?_____

Pharmacy? _____
Name Address City Phone Number

CURRENT DENTAL CONDITION:

Are you in pain?	YES	NO	
Do you have trouble chewing or speaking?	YES	NO	
Have you ever had periodontal (gum) treatments?	YES	NO	
Do your gums bleed, feel tender or irritated?		YES	NO
Are teeth sensitive to hot, cold, sweets, pressure?	YES	NO	
Do you wear dentures?		YES	NO
If yes, are you unhappy with your dentures?	YES	NO	
Do you want to know about permanent replacements?		YES	NO
Are you apprehensive about dental treatment?		YES	NO
Do you have headaches, earaches, or neck pain?	YES	NO	
Have you worn braces on your teeth?		YES	NO
Do you use cigars, cigarettes, a pipe, or chewing tobacco?	YES	NO	

GENERAL HEALTH HISTORY

Have there been any changes in your general health in the past year? YES NO
If yes, what has changed?_____

Have you had any illness, operation, or been hospitalized in the past five years? YES NO
If yes, please list_____
_____

Has anyone in your family, including you, had anesthetic problems during an operation? YES NO
Do you have unhealed injuries, inflamed areas, growths or spots in/around your mouth? YES NO

PLEASE LIST ANY DRUGS YOU ARE CURRENTLY TAKING:
_____
_____

Have you had ALLERGIC REACTIONS to any drug? YES NO
If yes, which?_____
What kind of reaction?_____
_____

Patient Name:_____

INDICATE WHICH OF THE FOLLOWING YOU HAVE OR EVER HAD

Circle "Yes" on each appropriate item.

Heart Failure	YES	Hepatitis A (infectious)	YES	Psychiatric treatment	YES		
Thyroid problems	YES	Hepatitis B (serum)	YES	High blood sugar/diabetes	YES		
Heart disease or heart attack	YES	Hepatitis C	YES	Liver disease	YES		
Kidney trouble	YES	Heart surgery	YES	Bruise easily	YES		
Congenital heart disease	YES	Heart pacemaker	YES	Ulcers	YES		
Stroke	YES	Rheumatic fever	YES	Alcoholism	YES		
Angina pectoris	YES	Cold sores/fever blisters	YES	Chronic fatigue/night sweats	YES		
Epilepsy or seizures	YES	Asthma	YES	Cancer	YES		
Heart Murmur	YES	Venereal disease	YES	Chronic cough	YES		
Sickle cell disease or trait	YES	Emphysema	YES	Chemotherapy	YES		
High blood pressure	YES	Drug addiction	YES	Sinus trouble	YES		
Anemia	YES	Tuberculosis	YES	Pain in jaw joints (TMJ)	YES		
Low blood pressure	YES	X-ray treatment/Radiation	YES	Low blood sugar	YES		
Hemophilia	YES	Hay fever	YES	Arthritis or Rheumatism	YES		
Arteriosclerosis	YES	Profuse bleeding	YES	Artificial joint: hip, knee, etc.	YES		
Blood transfusion	YES	Allergies or hives	YES	Cortisone medication	YES		
Mitral valve prolapse	YES	Fainting or dizzy spells	YES	Wear glasses/contact lenses	YES		
AIDS/RRC/HIV positive	YES	Nervousness	YES	Glaucoma	YES		
Artificial heart valve	YES	Yellow jaundice	YES	Cosmetic surgery	YES		

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired?	YES	NO
Do your ankles swell during the day?	YES	NO
Do you use more than two pillows to sleep?	YES	NO
Have you lost or gained more than 10 pounds in the last year?	YES	NO
Do you ever wake up from sleep and feel short of breath?	YES	NO
Are you on a special diet?	YES	NO
If yes, please explain_____		
Do you have or have you had any disease, condition, hospitalization or problem not listed here?	YES	NO
If yes, please explain_____		

FOR WOMEN ONLY

Is there a possibility of pregnancy?	YES	NO
If yes, estimated delivery date?_____		
Are you nursing?	YES	NO
Are you taking birth control pills?	YES	NO

Women Note: **Antibiotics may alter the effectiveness of birth control pills. Consult your physician or gynecologist for information regarding additional methods of birth control.**

CONSENT

I certify that all above questions were answered truthfully and to the best of my knowledge with the understanding that they were necessary to provide quality dental care in a safe and efficient manner.

_____

Patient Signature (or responsible party and relation to the patient) **Date**

_____

Doctor Signature **Date**