Christine J. Coke, DDS, MD, PA

Oral Surgery 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 the following questions. Your answers are for our records only and will be considered confidential. Thank You!

Patient Name: _____ D.O.B. _____

Reason for today's visit: _____

Who is your primary dentist? _____

Do you have a referral letter? YES NO _____

Pharmacy? _____

Name Address Phone #

Current Dental Condition

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

General health History

Height_____ Weight_____ lbs

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 5 years? YES NO

If yes, please list: _____

Have you or a family member had anesthesia problems during an operation? YES NO

Do you have injuries, inflamed areas, growth or spots in/around your mouth? YES NO

Are you currently taking or have you ever taken and bisphosphonate medications like Fosamax, Boniva, Actonel, Re-clast, or Zometa OR received Prolia/shots for osteoporosis or cancer? YES NO

If yes, when was your last dose and for how long did you take medication? _____

Please list any Medications you are currently taking:

_____

Have you had an Allergic Reactions to any Drug(s), Food(s), or Latex: _____

Patient Name:_____

INDICATE WHICH OF THE FOLOWING YOU HAVE OR EVER HAD

Circle" YES" on each appropriate item

Heart Failure	YES	Kidney Disease	YES	Chronic Fatigue/Night Sweats	YES
Heart Disease or Heart Attack	YES	AIDS/RRC/HIV Positive	YES	Cold Sores/Fever Blisters	YES
Heart Surgery	YES	Hepatitis	YES	Ulcers	YES
Congenital Heart Disease	YES	Tuberculosis	YES	Venereal Disease	YES
Heart Pacemaker	YES	Liver disease	YES	Crohn's Disease	YES
Heart Murmur	YES	Yellow Jaundice	YES	Ulcerative Colitis	YES
Stroke	YES	Diabetes	YES	Nervousness	YES
Angina Pectoris	YES	High/Low Blood Sugars	YES	Fainting or Dizzy Spells	YES
Coronary Heart Disease	YES	Cancer	YES	Epilepsy or Seizures	YES
Arteriosclerosis	YES	Chemotherapy	YES	Drug Addiction	YES
Mitral Valve Prolapse	YES	Radiation Treatment	YES	Alcoholism	YES
Artificial Heart Valve	YES	Thyroid Problems	YES	Psychiatric Treatment	YES
High/Low Blood Pressure	YES	Allergies or Hives	YES	Pain in Jaw Joints	YES
Hemophilia	YES	Asthma	YES	Cortisone Medication	YES
Blood Transfusion	YES	Emphysema	YES	Arthritis or Rheumatism	YES
Anemia	YES	Hay Fever	YES	Artificial Joint: Hip, Knee, etc	YES
Bruise Easily	YES	Rheumatic Fever	YES	Cosmetic Surgery	YES
Profuse Bleeding	YES	Sinus Trouble	YES	Wear Glasses/Contact Lens	YES
Sickle Cell Disease or Trait	YES	Chronic Cough	YES	Glaucoma	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 you ever wake up from sleep and feel short of breath? YES NO

Do your ankles swell during the day? YES NO

Do you use more than 2 pillows to sleep? YES NO

Have you lost or gained more than 10 pounds in the last year? YES NO

Are you on a special diet? YES NO

If yes, please explain:_____

Do you have or had any disease, conditions, hospitalization or problems 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 medication? YES NO

Women Note: Antibiotics may alter the effectiveness of birth control medication. 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 or Responsible Party _____ Date _____

Dr. Coke Signature _____ Date _____