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 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? _____

Who is your primary care physician? _____

Do you have a referral letter? YES NO

How were you referred to us? _____

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 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, 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_____

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

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

Are you currently taking or have you ever taken any bisphosphonate medications like Fosamax, Boniva, Actonel, Reclast, 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 them? _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

Have you had ALLERGIC REACTIONS to any drug? YES NO
If yes, what medication and reaction did you have?

_____

Patient Name: _____

INDICATE WHICH OF THE FOLLOWING YOU HAVE OR EVER HAD

Circle "Yes" or "No" on each appropriate item.

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

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 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**