Date: _____

ALTAMONTE IMPLANT & COSMETIC DENTISTRY

D5 IMPLANT SOLUTION CENTERS

Dr. Atila C. Miranda, Prosthodontist

DENTAL & MEDICAL HEALTH HISTORY FORM

Patient Name: _____ _____ _____
Last Name First Name Middle Initial

Date of Birth ___/___/___ Gender _____ Male _____ Female

Address: _____

E-mail: _____

Mobile Phone Number: _____ Home Phone Number: _____

Employer/Occupation: _____ Work Number: _____

Spouse/Partner's Name: _____ Phone Number: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Dental History:

Reason for today's visit _____ Date of last dental visit _____

Bad Breath	Yes	No	Grinding Teeth	Yes	No	Periodontal Treatment	Yes	No
Bleeding Gums	Yes	No	Gums Swollen or Tender	Yes	No	Sensitivity to Cold	Yes	No
Blisters on Lips or Mouth	Yes	No	Loose Teeth or Broken Fillings	Yes	No	Sensitivity to Hot	Yes	No
Burning Sensation on Tongue	Yes	No	Mouth Breathing	Yes	No	Sensitivity to Sweets	Yes	No
Clicking or Popping Jaw	Yes	No	Mouth Pain, Brushing	Yes	No	Sensitivity when Biting	Yes	No
Dry Mouth	Yes	No	Orthodontic Treatment	Yes	No	Sores or Growths in Mouth	Yes	No

Medical History:

Medical Alert: _____ Premed: _____

Has there been any change in your health in the past year? Yes No

If yes, what condition is being treated? _____

Date of last physical ____/____/____

Physician Name: _____

Address: _____ City/state/zip: _____

Phone #: _____

Have you had any serious illness, operations or been hospitalized in the past 5 years? Yes No

If yes, what was the illness or problem? _____

Have you ever used a bisphosphonate medication?
Common brand names are Fosamax, Actonel, Atelvia, Didronel, Bonvia Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" Yes No
These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Do you, or have you, had any of the following diseases or problems? CIRCLE Yes OR No

AIDS/HIV	Yes	No	Do you wear			Psychiatric Care	Yes	No
Anemia	Yes	No	Contact Lenses?	Yes	No	Radiation Treatment	Yes	No
Arthritis, Rheumatism	Yes	No	Epilepsy	Yes	No	Respiratory Disease	Yes	No
Artificial Heart Valve	Yes	No	Fainting or Dizziness	Yes	No	Rheumatic Fever	Yes	No
Artificial Joints	Yes	No	Glaucoma	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	Headaches	Yes	No	Shortness of Breath	Yes	No
Back Problems	Yes	No	Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Heart Problems	Yes	No	Skin Rash	Yes	No
Blood Transfusion	Yes	No	Hepatitis Type _____	Yes	No	Special Diet	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Chemical Dependency	Yes	No	High Blood Pressure	Yes	No	Swollen Feet or Ankles	Yes	No
Chemotherapy	Yes	No	Jaundice	Yes	No	Swollen Neck Glands	Yes	No
Circulatory Problems	Yes	No	Jaw Pain	Yes	No	Thyroid Problems	Yes	No
Congenital Heart Lesions	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No
Cortisone Treatment	Yes	No	Liver Disease	Yes	No	Tumor or Growth on Neck	Yes	No
Cough, Persistent or Bloody	Yes	No	Low Blood Pressure	Yes	No	Ulcer	Yes	No
Dementia	Yes	No	Mitral Valve Prolapse	Yes	No	Venereal Disease	Yes	No
Diabetes Type _____	Yes	No	Nervous Problems	Yes	No	Weight Loss, Unexplained	Yes	No
Emphysema	Yes	No	Pacemaker	Yes	No			

WOMEN ONLY Are you: Pregnant? Yes No If yes, how many weeks: _____

Taking birth control pills or hormonal replacement? Yes No Nursing? Yes No

Joint Replacement

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No

Date: _____ Do you need to pre-medicate (take antibiotics before any dental appointment)? Yes No

Do you use tobacco (smoking, snuff, chew) Yes No

Do you use controlled substances (drugs) Yes No

Are you taking any of the following:

Antibiotics or Sulfa Drugs	Yes	No
Anticoagulants or Blood Thinners	Yes	No
Medicine for High Blood Pressure	Yes	No
Cortisone or Steroids	Yes	No
Tranquilizers	Yes	No
Insulin or Medication for Blood Sugar	Yes	No
Aspirin on a Regular Basis	Yes	No

Other (please list)

List of Medications:

_____

_____

_____

Are you allergic or have you had a reaction to:

Aspirin	Yes	No
Local Anesthetics	Yes	Nos
Barbiturates (Sleeping Pills)	Yes	No
Codeine	Yes	No
Iodine	Yes	No
Latex	Yes	No
Metal	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No

List of Other Allergies:

_____

_____

_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if an, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____