Shenandoah Valley Implant Institute, LLC

Medical History

Patient Name ______________________ Date of Birth ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? .... Yes No If yes, please explain ______________

Doctor's Name______________________ Phone ______________

Have you ever been hospitalized or had a major operation? .... Yes No If yes, please explain ______________

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Have you ever had a serious head or neck injury? .... Yes No If yes, please explain ______________

Are you taking any perscribed medications, pills or drugs, add over the counter, herbs or supplements and also dosage? Yes No

If yes, please list with dosage ______________

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Do you take, or have you taken, Pehn-Fen or Redux? .... Yes No If yes, please explain______________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphates? .... Yes No If yes, please explain______________

Are you on a special diet? .... ○ Yes No If yes, please explain______________

Do you use tobacco (smoke or smokeless) .... Yes No If yes, how much/often______________

Do you use a control substance (recreational drug)? .... Yes No If yes, please explain ______________

Have you been recommended to have a sleep apnea test?.... Yes No If yes, do you have: A CPAP, sleep appliance No current sleep device

Are you happy with your CPAP, sleep appliance? .... Yes No

Women: Are you pregnant/trying to get pregnant? .... Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you Allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics Acrylic Latex Sulfa drugs Other If yes, please explain ______________

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

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
									Yellow Jaundice	Yes	No

continues on reverse

Have you ever had any serious illness not listed on reverse? Yes No

Your greatest medical risk? ____

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Additional Comments____

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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 ______________

PROVIDER USE ONLY

Date ______________ SVII Initials ______________ Any Changes______________________________

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Date ______________ Patient Initials ______________

Date ______________ SVII Initials ______________ Any Changes______________________________

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Date ______________ Patient Initials ______________