

NP - Patient Health Information

First Name - Patient *

Middle Name

Last Name - Patient *

Patient Date of Birth



Gender *

Male Female Other

Occupation

PHONE/CONTACT INFORMATION

Mobile #

Home #

Email Address

Preferred Contact Method

Emergency contact

Emergency #

Patient Mailing Address

Line 1

Line 2

City

Country

Patient Billing Address

Line 1

Line 2

City

Country

MEDICAL/HEALTH HISTORY

Primary Care Doctor and Office Name

Physician Phone #

Date of last physical exam

Have you ever used or will schedule to start an antiresorptive agent (like Fosamax, Zometa, Reclast, Prolia, Aredia, XGEVA, Actonel, Atelvia, Boniva) for osteoporosis, bone pain, metastatic cancer or Paget's disease? *

Yes No

In the past 5 years, have you ever been hospitalized or had any type of surgery?

Yes No

Have you ever been instructed to take ANY special precautions or medications before any dental appointments?

Yes No

Do you smoke or vape?

Yes No

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Yes No

Have you ever been diagnosed with sleep apnea?

Yes No

Are you pregnant?

Yes No

If yes, number of weeks?

Are you currently nursing?

Yes No

Are you taking birth control or hormone replacement?

Yes No

DENTAL/ORAL HEALTH HISTORY

Please check the boxes for all YES answers

- Are you currently experiencing dental pain or discomfort?
- Are your teeth sensitive to cold, hot, sweets, or pressure?
- Do you grind your teeth?
- Do you have any clicking, popping, or discomfort in your jaw?
- Have you ever had a serious injury to your head, neck, or mouth?

PHARMACY INFORMATION

Preferred Pharmacy

Pharmacy #

Allergies

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Acetaminophen/Tylenol® | <input type="checkbox"/> Food | <input type="checkbox"/> Mint |
| <input type="checkbox"/> Acrylic | <input type="checkbox"/> Hay fever/seasonal | <input type="checkbox"/> Other |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen/Motrin®/Advil® | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Local anesthetic | |
| <input type="checkbox"/> Fluoride | <input type="checkbox"/> Metals | |
| <input type="checkbox"/> Other | | |

Please elaborate on any reactions you have to the indicated allergies

CONDITIONS

Medications

- | | | |
|--|---|--|
| <input type="checkbox"/> Adderall / Ritalin | <input type="checkbox"/> Famotidine (Pepcid, Zantac) | <input type="checkbox"/> Pain Meds (Prescription) |
| <input type="checkbox"/> Albuterol | <input type="checkbox"/> Fish Oil | <input type="checkbox"/> Pantoprazole |
| <input type="checkbox"/> Alprazolam (Xanax / Ativan) | <input type="checkbox"/> Gabapentin | <input type="checkbox"/> Prednisone |
| <input type="checkbox"/> Amlodipine (Norvasc) | <input type="checkbox"/> Hydrochlorothiazide | <input type="checkbox"/> Prozac |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Insulin | <input type="checkbox"/> Ranitidine (Zantac) |
| <input type="checkbox"/> Apixaban (Eliquis) | <input type="checkbox"/> Levothyroxine | <input type="checkbox"/> Rivaroxaban (Xarelto) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Lisinopril | <input type="checkbox"/> Rosuvastatin (Crestor) |
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Metformin (Glucophage) | <input type="checkbox"/> Sertraline (Zoloft) |
| <input type="checkbox"/> Bisphosphonates | <input type="checkbox"/> Metoprolol | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Cetirizine (Zyrtec) | <input type="checkbox"/> Omeprazole (Prilosec) | <input type="checkbox"/> Vyvanse |
| <input type="checkbox"/> Clopidogrel (Plavix) | <input type="checkbox"/> Ozempic | <input type="checkbox"/> Warfarin (Coumadin) |
| <input type="checkbox"/> Denosumab (Prolia) | <input type="checkbox"/> Pain Meds (Over the Counter) | <input type="checkbox"/> Zoledronic Acid (Reclast) |
| <input type="checkbox"/> Other | | |

Conditions

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal/excessive bleeding | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> AIDS or HIV infection | <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Neurological disorders |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis/Paget's disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting spells or seizures | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Gastrointestinal disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> G.E. Reflux/persistent heartburn | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Severe headaches/migraines |
| <input type="checkbox"/> Cancer/chemotherapy/radiation treatment | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest pain upon exertion | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Systemic lupus erythematosus |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hepatitis, jaundice or liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital heart dis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Other | <input type="checkbox"/> Kidney Disease | |

Do you have any disease, condition or problem that is not listed that you think I should know about?

Signature

Clear

