HEALTH INFORMATION

ARIVE a FAMILY DENTAL

CRAIG ARIVE D.D.S.

OWN YOUR SMILE

Date:

If you answer yes to any of the 3 items below, please stop and return this form to the desk.

Have you had any of the following?

Active Tuberculosis:
❍ Yes ❍ No

Persistent cough greater than a 3 week duration:
❍ Yes ❍ No

Cough that produces blood:
❍ Yes ❍ No

FOR COMPLETION BY STAFF

Medical Alert:
❍ Yes ❍ No

Dental management consideration(s):

Premedication:
❍ Yes ❍ No

Allergies:

Patient First Name: *Last Name:* *Birthdate (mm/dd/year):* / /

Gender: ❍ Male ❍ Female

MEDICAL INFORMATION

Name of your Primary Physician: *Phone:*

Street Address: *Date of last visit (estimated month and year):*

City, State, Zip Code:

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

Are you now under the care of a physician? ❍ Yes ❍ No

If yes, what is/are the condition(s) being treated?

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

If yes, what was the illness or problem?

Are you taking or have you taken Oral Bisphosphonates or IV bisphosphonates (i.e. Fosamax, Actonel, Boniva, Zometa, Aredia)? ❍ Yes ❍ No

Are you taking or have you taken any steroid/cortisone therapy in the last two years? ❍ Yes ❍ No

Have you ever taken Phen-fen? ❍ Yes ❍ No

Have you experienced an adverse reaction to local anesthetic? ❍ Yes ❍ No

Are you allergic to latex? ❍ Yes ❍ No

Are you allergic to metal? ❍ Yes ❍ No

DO YOU HAVE OR DID YOU EVER HAVE ANY OF THE FOLLOWING?

Cardiovascular Health

High Blood Pressure/Hypertension ❍ Yes ❍ No
Low blood pressure ❍ Yes ❍ No
Angina or heart attack ❍ Yes ❍ No
Chest pain on physical exertion ❍ Yes ❍ No
Congestive heart failure ❍ Yes ❍ No
Coronary artery blockage, arteriosclerosis or treatment (bypass, stent, etc.) ❍ Yes ❍ No
Damaged heart valve/ mitral valve prolapse ❍ Yes ❍ No
Artificial heart valve ❍ Yes ❍ No
Heart murmur ❍ Yes ❍ No
Congenital heart defect ❍ Yes ❍ No
Rheumatic fever ❍ Yes ❍ No
Irregular heartbeat or pacemaker ❍ Yes ❍ No
Stroke ❍ Yes ❍ No
Endocarditis ❍ Yes ❍ No

Respiratory Health

Asthma ❍ Yes ❍ No
COPD/emphysema ❍ Yes ❍ No
Chronic sinus/allergy problems ❍ Yes ❍ No
Sleep apnea/disorder ❍ Yes ❍ No
Tuberculosis (inactive) ❍ Yes ❍ No

Neurological Health

Fainting spells or dizziness ❍ Yes ❍ No
Anxiety/Nervousness ❍ Yes ❍ No
Seizures/Epilepsy ❍ Yes ❍ No
Numbness or muscle weakness ❍ Yes ❍ No
Multiple sclerosis ❍ Yes ❍ No
Parkinson's ❍ Yes ❍ No

Endocrine

Thyroid problems ❍ Yes ❍ No
Diabetes ❍ Yes ❍ No
Type I (insulin dependent): *Type II:*

Blood/Immune Health

Allergies or Hives ❍ Yes ❍ No
Lichen planus ❍ Yes ❍ No
Sjogrens syndrome ❍ Yes ❍ No
Anemia/blood disease ❍ Yes ❍ No
Abnormal bleeding, bruise easily ❍ Yes ❍ No
Hemophilia ❍ Yes ❍ No
Blood transfusion ❍ Yes ❍ No
Recurrent infections ❍ Yes ❍ No
Type:

Cancer ❍ Yes ❍ No
Type:
Radiation therapy ❍ Yes ❍ No
Chemotherapy ❍ Yes ❍ No
Organ transplant ❍ Yes ❍ No

Muscular-Skeletal Health

Joint replacement ❍ Yes ❍ No
Arthritis ❍ Yes ❍ No
Osteoporosis ❍ Yes ❍ No
Chronic pain ❍ Yes ❍ No

Gastro-Intestinal/Genito-Urinary Health

Liver disease ❍ Yes ❍ No
Kidney disease/dialysis ❍ Yes ❍ No
Frequent urination ❍ Yes ❍ No
Ulcers ❍ Yes ❍ No
Gastric Reflux/heartburn ❍ Yes ❍ No
Severe or rapid weight loss ❍ Yes ❍ No
Crohn's disease ❍ Yes ❍ No

Infectious Diseases

Hepatitis ❍ Yes ❍ No
Herpes ❍ Yes ❍ No
HPV ❍ Yes ❍ No
HIV positive/AIDS ❍ Yes ❍ No
Syphilis ❍ Yes ❍ No

PLEASE COMPLETE BOTH SIDES

Mental Health and Behavioral Disorders

Psychosis (Bipolar disorder, depression, schizophrenia) ❍ Yes ❍ No
Type: .....
Dementia ❍ Yes ❍ No
Alzheimer's disease ❍ Yes ❍ No
Autism ❍ Yes ❍ No
Cerebral Palsy ❍ Yes ❍ No
Other: .....

Social Behaviors

Eating disorder ❍ Yes ❍ No
Use of tobacco products (smoking, chew, snuff) ❍ Yes ❍ No
Packs per week: ..... *No. years:* .....
Do you consume alcoholic beverages? ❍ Yes ❍ No
No. drinks per week: .....
Do you use recreational drugs? ❍ Yes ❍ No
Have you undergone addiction therapy? ❍ Yes ❍ No

OTHER DISEASE OR ILLNESS

Do you have any disease, condition, or problem not listed that you think I should know about? ❍ Yes ❍ No

Please explain: .....

FEMALES ONLY

Is there a possibility of pregnancy? ❍ Yes ❍ No
Estimated delivery date: .....
Are you nursing now? ❍ Yes ❍ No
Are you taking birth control or hormones? ❍ Yes ❍ No

MEDICATIONS

Are you taking or have you recently taken any medicine(s) including non-prescription medicine? ❍ Yes ❍ No

If yes, list all prescribed and non-prescribed/over-the-counter medicines.

.....

Please list all vitamins, dietary supplements, and herbal preparations you are taking:

.....

Pharmacy Name: *Location:* *Phone:*

.....

Are you allergic or have you had a reaction to?
Aspirin ❍ Yes ❍ No
Penicillin ❍ Yes ❍ No
Sulfa drugs ❍ Yes ❍ No
Barbituates, sedatives, or sleeping pills ❍ Yes ❍ No
Codeine or other narcotics ❍ Yes ❍ No
To yes responses, specify type of reaction:

.....

DENTAL INFORMATION

Date of last dental exam (estimated month and year):

.....

Date of last dental x-rays (estimated month and year):

.....

How do you feel about the appearance of your smile/teeth?

.....

Do your gums bleed when you brush? ❍ Yes ❍ No
Have you had any periodontal (gum) treatments? ❍ Yes ❍ No
Have you had a serious/difficult problem associated with any previous dental treatment? ❍ Yes ❍ No
If yes, please explain:

.....

Do you experience chronic canker sores? ❍ Yes ❍ No
Have you noticed any new lumps, bumps, or sores in your mouth? ❍ Yes ❍ No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of the staff, responsible for any actions they take or do not take because of error or omissions that I have made in the completion of this form.

Patient Signature: *Date (mm/dd/year):*

/ /

STOP!

THE FOLLOWING IS TO BE COMPLETED ONE YEAR AFTER INITIAL INQUIRY

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/ /

THANK YOU!