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PERIODONTICS & DENTAL IMPLANTS

DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

PHYSICIAN _____

ADDRESS _____ CITY _____ PHONE _____

YOUR AGE _____ HEIGHT _____ WEIGHT _____ MO/YEAR OF YOUR LAST MEDICAL EXAMINATION _____

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH (CIRCLE ONE): EXCELLENT GOOD FAIR POOR DON'T KNOW

YES NO ???

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?

HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR HOSPITALIZATION DURING THE PAST FIVE YEARS?

IF YES, PLEASE DESCRIBE _____

ARE YOU TAKING OR HAVE YOU RECENTLY TAKEN ANY OF THE FOLLOWING:

PRESCRIBED MEDICATIONS & INHALERS:

OVER THE COUNTER, NATURAL OR HERBAL PREPARATIONS:

HAVE YOU EVER RECEIVED I.V., OR TAKEN ORALLY: AREDIA, ZOMETA , FOSAMAX OR ANY OTHER BISPHOSPHONATES ?

HAVE YOU EVER TAKEN PONDIMIN (FENDLURAMINE) , PHEN-FEN (PHENTERMINE) OR REDUX (DEXPHENFLURAMINE) FOR WEIGHT REDUCTION?

HAS YOUR M.D. TOLD YOU TO TAKE ANTIBIOTICS PRIOR TO HAVING ANY TYPE OF DENTAL PROCEDURE?

ARE YOU ALLERGIC TO ANY MEDICATIONS OR DRUGS, LATEX, IODINE?

HAVE YOU EVER HAD ADVERSE REACTION TO ANY DRUGS, ANESTHETICS, SEDATIVES, NARCOTICS, ASPIRIN, IBUPROFEN (MOTRIN)?

HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT?

HAVE YOU BEEN DIAGNOSED AS HAVING ANY IMMUNODEFICIENCY, SYSTEMIC LUPUS, ARC OR AIDS?

IS THERE A HISTORY OF DIABETES IN YOUR FAMILY?

ARE YOU REQUIRED, DUE TO HEALTH, TO RESTRICT YOUR WORK OR ACTIVITY IN ANY WAY?

ARE YOU ON A SPECIAL OR RESTRICTED DIET OF ANY KIND? _____

DO YOU USE ANY KIND OF TOBACCO? IF SO HOW MUCH: _____ PER DAY, WEEK, MONTH

DO YOU USE ANY KIND OF ALCOHOL? IF SO HOW MUCH: _____ PER DAY, WEEK, MONTH

DO YOU HAVE ANY HISTORY OF SUBSTANCE ABUSE OR DO YOU CURRENTLY USE RECREATIONAL DRUGS?

FOR WOMEN, CHECK ALL THAT ARE APPROPRIATE: I AM PREGNANT I AM NURSING I AM TAKING BIRTH CONTROL PILLS

CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:

CHEST PAIN UPON EXERTION

RECEIVED BLOOD TRANSFUSION

SLEEP APNEA

HEADACHES

SHORTNESS OF BREATH

IMPAIRED LIVER FUNCTION

ASTHMA

MIGRAINES

HIGH BLOOD PRESSURE

KIDNEY DISEASE

BRONCHITIS

EPILEPSY

LOW BLOOD PRESSURE

IMPAIRED KIDNEY FUNCTION

EMPHYSEMA

SEIZURES

HEART VALVE PROSTHESIS

ESOPHYGEAL REFLUX

SINUS TROUBLES

MENTAL HEALTH PROBLEMS

MITRAL VALVE PROLAPSE

HIATAL HERNIA

PERSISTENT COUGH

RECURRENT INFECTIONS

CONGENITAL HEART LESION

G.I. ULCERS

TUBERCULOSIS

WEAR CONTACT LENSES

RHEUMATIC FEVER

ANOREXIA OR BULEMIA

JOINT REPLACEMENT SURGERY

SEVERELY IMPAIRED VISION

HEART MURMUR

IRRITABLE BOWEL SYNDROME

CONNECTIVE TISSUE DISORDER

DAMAGED HEART VALUE

COLITIS

ARTHRITIS

HEART ARRHYTHMIA

DIABETES

RECENT WEIGHT LOSS

TACHYCARDIA

OSTEOPOROSIS

CHRONIC FATIGUE

HEART SURGERY

RADIATION THERAPY

GLAUCOMA

CARDIAC PACEMAKER

CHEMOTHERAPY

NEUROLOGICAL DISORDERS

HEPATITIS OR JAUNDICE

HISTORY OF CANCER

STROKE

GLAUCOMA

Do you have any disease, problem or condition not listed above? Please explain:

Signature of patient or legal guardian

Date

Reviewed by