The Smile Zone
576 Sand Creek Road
Albany, NY 12205

(518)869-5348

## Medical History/Amendment

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Name, address and phone number of your medical doctor

Name and phone number of your preferred pharmacy

Have you had a serious illness or operation? If yes, please explain

Are you allergic or have you had a reaction to any medications, food, latex or anesthetics

Have you had or do you have any of the following health conditions? Check all that apply

- ☐ Alzheimers/Dementia
- ☐ Anemia
- ☐ Anticoagulant Use
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ ArtificialHeartValve
- ☐ Asthma
- ☐ Autism
- ☐ Blood Disorder
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Clindamycin Allergy
- ☐ Codeine Allergy
- ☐ Defibrilator
- ☐ Diabetes
- ☐ Dizziness/Vertigo
- ☐ Downs Syndrome
- ☐ Drug/alcohol abuse
- ☐ Ear pain/ringing
- ☐ Epilepsy
- ☐ Epinephrine reaction
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Food Allergy
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Immune Disorders
- ☐ Intestinal Disorders
- ☐ Jaw pain/clicking
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Metal Allergy
- ☐ Mitral ValveProlapse
- ☐ Neurologic Disorders
- ☐ Oral Surgery
- ☐ Organ Transplant
- ☐ Orthodontics/Braces

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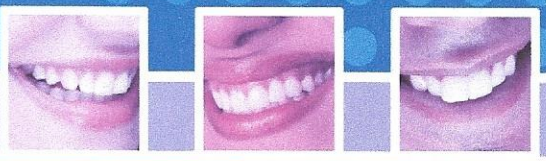

- [ ] Osteoporosis
- [ ] Other Drug Allergies
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] Periodontal Disease
- [ ] Pregnancy/Nursing
- [ ] Premedication needed
- [ ] Psychiatric disorder
- [ ] Radiation Treatment
- [ ] Respiratory problems
- [ ] Root Canal Treatment
- [ ] Seasonal Allergies
- [ ] Sinus Problems
- [ ] Spectrum Disorders
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Allergy
- [ ] Thyroid Condition
- [ ] Tobacco Use
- [ ] Tuberculosis

Do you have any other conditions or diseases not listed that we should be aware of

Do you or have you ever taken bisphosphonate medications (Fosamax, Boniva etc)

Are you taking any of the following medications

- [ ] Antibiotics
- [ ] Medication for high blood pressure
- [ ] Cortisone or steroids
- [ ] Anticoagulants or blood thinners (including daily aspirin)
- [ ] Tranquilizers
- [ ] Antihistamines
- [ ] Insulin or other medications for diabetes
- [ ] Medication for heart problems including nitroglycerin
- [ ] Oral contraceptives or hormonal therapy
- [ ] Vitamins, herbal supplements or fluoride vitamins (for children under 14)

Please list all medications you are taking

- [ ] I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omission that I may have made in completion of this form.