

# The Smile Zone

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(518)869-5348

## Medical History/Amendment

**Patient Name:** \_\_\_\_\_  
Last First MI Preferred Name

**Name, address and phone number of your primary care doctor:**

**Name and address of your preferred pharmacy**

**Are you allergic or have you had a reaction to any medications, food, latex or anesthetics? If yes please list/explain**

**Do you have or do you have a history of the following conditions? Please check all that apply.**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Alzheimers/Dementia  | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Anticoagulant Use    | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> ArtificialHeartValve | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Blood Disorder       |
| <input type="checkbox"/> C. Diff Infection    | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Chemotherapy         | <input type="checkbox"/> Defibrillator        |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Dizziness/Vertigo    | <input type="checkbox"/> Downs Syndrome       | <input type="checkbox"/> Drug/alcohol abuse   |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Epinephrine reaction | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Fainting             |
| <input type="checkbox"/> Food Allergy         | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Head Injuries        | <input type="checkbox"/> Heart Attack         |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> High Cholesterol     |
| <input type="checkbox"/> HIV/AIDS             | <input type="checkbox"/> Immune Disorders     | <input type="checkbox"/> Intestinal Disorders | <input type="checkbox"/> Jaw Clicking         |
| <input type="checkbox"/> Jaw pain             | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Medication Allergy   |
| <input type="checkbox"/> Metal Allergy        | <input type="checkbox"/> Neurologic Disorders | <input type="checkbox"/> Oral Surgery         | <input type="checkbox"/> Organ Transplant     |
| <input type="checkbox"/> Orthodontics/Braces  | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Periodontal Disease  |
| <input type="checkbox"/> Premedication needed | <input type="checkbox"/> Psychologic disorder | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> Sleep Apnea          | <input type="checkbox"/> Spectrum Disorders   | <input type="checkbox"/> Stomach Problems     |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Thyroid Condition    | <input type="checkbox"/> Tuberculosis         |   |

**Are you currently pregnant? Due date:** \_\_\_\_\_

**Are you currently nursing?** \_\_\_\_\_

**Do you use or have a history of using tobacco products (cigarettes, chewing tobacco, vaping etc)? If yes, how much per day**

**For diabetic patients, date and value of your last a1c** \_\_\_\_\_

**Please list any and all surgeries or operations you have had**

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

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**Have you ever taken bisphosphonate medications such as Fosamax or Boniva? \_\_\_\_\_**

**Are you taking any of the following medications**

- Antibiotics
- Medication for high blood pressure
- Medication for high cholesterol
- Cortisone or steroids
- Anticoagulants/ blood thinners including aspirin
- Medication for anxiety/depression/other psychological conditions
- Insulin or other medications for diabetes
- Medication for heart problems including nitroglycerin
- Medication for cancer/chemotherapy
- Oral contraceptives or hormonal therapy
- Vitamins, supplements, herbals

**Please list all medications/creams/drops, vitamins and supplements you take/use**

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**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.**

**Signature: \_\_\_\_\_**

**Additional Information**

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**Response Date: \_\_\_\_\_**