MAXILLO
SPECIALISTS Saleh Robin Dao

MEDICAL HISTORY

Physician ________________ Telephone ________________
Dentist ________________ Telephone ________________
Are you presently under a doctor's care? Yes ◯ No ◯
If so, why? ________________

- Are you a smoker? Yes ◯ No ◯
- Are you pregnant? Yes ◯ No ◯
- Are you nursing? Yes ◯ No ◯

Do you consume illegale substances (drugs) or have you in the past six months? Yes ◯ No ◯

Are you presently taking medication, or have you taken any in the last six months? Yes ◯ No ◯

- Anticoagulants (blood thinner) Yes ◯ No ◯
- Bisphosphonates (osteoporosis) Yes ◯ No ◯
- Intravenous Bisphosphonates (for bone tumor) Yes ◯ No ◯
- Oral contraceptives Yes ◯ No ◯
- For multiple myeloma Yes ◯ No ◯
- Other medication, get the list from your pharmacy Yes ◯ No ◯

Do you have any of the following allergies?

- Anesthesia Yes ◯ No ◯
- Aspirin Yes ◯ No ◯
- Food Yes ◯ No ◯
- Iodine Yes ◯ No ◯
- Latex Yes ◯ No ◯
- Penicillin Yes ◯ No ◯
- Sulfonamide Yes ◯ No ◯
- Other allergies ________________

Do you suffer or have you suffered from?

- Anemia Yes ◯ No ◯
- Arthritis Yes ◯ No ◯
- Asthma Yes ◯ No ◯
- Blood pressure: high ◯ low ◯ Yes ◯ No ◯
- Diabetes Yes ◯ No ◯
- Digestive problems Yes ◯ No ◯
- Earaches Yes ◯ No ◯
- Epilepsy Yes ◯ No ◯
- Eye problems Yes ◯ No ◯
- Fainting spells Yes ◯ No ◯
- Frequent colds or sinusitis Yes ◯ No ◯
- Frequent headaches Yes ◯ No ◯
- Hay fever Yes ◯ No ◯
- Heart disease Yes ◯ No ◯
- Kidney disease Yes ◯ No ◯
- Liver diseases (hepatitis, cirrhosis) Yes ◯ No ◯
- Nervous disorders Yes ◯ No ◯
- Prolonged bleeding Yes ◯ No ◯
- Rheumatic fever Yes ◯ No ◯
- Sexually transmitted diseases (STI) Yes ◯ No ◯
- Skin diseases Yes ◯ No ◯
- Thyroid problems Yes ◯ No ◯
- Tuberculosis / Lung problems Yes ◯ No ◯

Have you ever had radiotherapy or chemotherapy treatments (tumor)? Yes ◯ No ◯
Are you HIV positive? Yes ◯ No ◯

CONFIDENTIAL INFORMATION

Last Name ________________
First Name ________________
Address ________________ Apt ______
City ________________ Postal Code ________________
Home Phone ________________
Work Phone ________________
Mobile ________________
Email ________________
Birthdate (yy/mm/dd) _____ /_____ /_____ F ◯ M ◯
Weight ________________ Height ________________
Medicare Number ________________
Expiration Date _____ /_____
Referred By ________________
Reason for visit ________________
Do you have any x-rays with you? Yes ◯ No ◯
Person responsible for payment if other than you
____
Do you have a dental insurance plan? Yes ◯ No ◯

I, undersigned, have read, understood and completed this medical questionnaire to the best of my knowledge and have asked the necessary questions.

Date _____ /_____ /_____
Signature ________________

INFORMED CONSENT

I herby consent to the treatments as described, and I recognize that Dr ________________ has explained the treatments, and the other options and possible complications, and that he has answered my questions satisfactorily.

Date _____ /_____ /_____
Signature ________________

Notes ________________
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