FAY DENTISTRY
BIOMIMETIC | AESTHETICS | OCCLUSION

16 Old Riverhead Road
Westhampton, NY 11978
631.288.9000

MEDICAL HISTORY

Patient Name: LAST _____ FIRST _____ Birthdate: _____

Name of Physician/and their specialty: _____ Phone #: _____

Date of most recent physical examination: _____ Purpose: _____

Are you aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)? ☐ YES ☐ NO

Have you ever been hospitalized? ☐ YES ☐ NO

If yes, discuss: _____

DO YOU HAVE or HAVE YOU EVER HAD:

	HEART/ BLOOD	YES	NO
1.	heart problems or cardiac stent within the past six months	☐	☐
2.	history of infective endocarditis	☐	☐
3.	artificial heart valve, repaired heart defect (PFO)	☐	☐
4.	heart pacemaker or implantable defibrillator or stent or other heart surgery	☐	☐
5.	heart murmur, mitral valve prolapse, rheumatic or scarlet fever	☐	☐
6.	high or low blood pressure	☐	☐
7.	arrhythmia	☐	☐
8.	angina (chest pain)	☐	☐
9.	heart attack/ failure	☐	☐
10.	congenital heart disorder	☐	☐
11.	arteriosclerosis	☐	☐
12.	stroke (taking blood thinners)	☐	☐
13.	high cholesterol or taking statins	☐	☐
14.	other heart trouble/ disease	☐	☐
15.	anemia or other blood disorder	☐	☐
16.	bruise easily or prolonged bleeding due to a slight cut (or INR > 3.5)	☐	☐
17.	recent blood transfusion	☐	☐

	RESPIRATORY	YES	NO
18.	lung disease	☐	☐
19.	pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
20.	chronic ear infections, tuberculosis, measles, chicken pox	☐	☐

	AUTOIMMUNE/ BONE	YES	NO
38.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates)	☐	☐
39.	arthritis or gout	☐	☐
40.	autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma)	☐	☐
41.	allergies (pollen/dust), hives, skin rash, hay fever	☐	☐
42.	persistent swollen neck glands or lymph nodes	☐	☐
43.	organ transplant	☐	☐
44.	orthopedic or soft tissue implant (e.g. joint replacement, breast implant)	☐	☐
45.	any lumps or swelling in the mouth	☐	☐
46.	pain in jaw joint	☐	☐
47.	cortisone/steroid therapy	☐	☐

	CANCER	YES	NO
48.	tumor/ abnormal growth	☐	☐
49.	X-ray treatments (radiation), chemotherapy or immunosuppressive medication	☐	☐

	INFECTION	YES	NO
50.	viral (e.g. herpes, cold sores) or bacterial (e.g. Lyme disease) infections	☐	☐
51.	STI / STD / HPV	☐	☐
52.	hepatitis (type _____)	☐	☐
53.	HIV Positive/ AIDS	☐	☐

	NEUROLOGICAL/ HEAD	YES	NO
54.	glaucoma	☐	☐

21. breathing problems (e.g. asthma, stuffy nose, sinus congestion); sinus trouble; deviated septum ☐ ☐
22. mouth breather or tongue tie ☐ ☐
23. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, daytime sleepiness, bed wetting) ☐ ☐
24. frequent cough ☐ ☐
25. vertigo ☐ ☐

LIVER/ KIDNEY/ ENDOCRINE **YES** **NO**

26. kidney disease or renal dialysis ☐ ☐
27. liver disease or jaundice ☐ ☐
28. thyroid disease, parathyroid disease or calcium deficiency ☐ ☐
29. hormone deficiency or imbalance (e.g. polycystic ovarian syndrome) ☐ ☐
30. diabetes (HbA1c = _____) ☐ ☐
31. excessive thirst ☐ ☐
32. hypoglycemia ☐ ☐
33. prostate disorders ☐ ☐

GASTRO-INTESTIONAL **YES** **NO**

34. stomach or duodenal ulcer ☐ ☐
35. digestive or eating disorders (e.g. gastric reflux, bulimia, anorexia, celiac disease, Chron's disease or inflammatory bowel disease) ☐ ☐
36. hernia ☐ ☐
37. recent weight loss ☐ ☐
55. contact lenses ☐ ☐
56. head or neck injuries ☐ ☐
57. epilepsy, convulsions (seizures) ☐ ☐
58. fainting or dizziness ☐ ☐
59. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) ☐ ☐
60. migraines or frequent headaches ☐ ☐
61. difficulties with stress management ☐ ☐
62. nervousness ☐ ☐
63. emotional difficulties ☐ ☐
64. psychiatric treatment, antidepressants, mood stabilizing medications ☐ ☐
65. concentration problems or ADD/ ADHD ☐ ☐

ARE YOU **YES** **NO**

66. taking dietary supplements, vitamins, and/or probiotics ☐ ☐
67. often exhausted or fatigued ☐ ☐
68. experiencing frequent headaches or chronic pain ☐ ☐

Any other medical conditions not checked above?

☐ YES ☐ NO If yes, discuss:

List all medications, supplements, and or vitamins taken within the last two years.
Please list the purpose or reason for taking each medication you have entered below.

EXISTING PATIENTS Check the box next to any medication no longer being taken.

1. ☐ _____
2. ☐ _____
3. ☐ _____
4. ☐ _____
5. ☐ _____
6. ☐ _____
7. ☐ _____
8. ☐ _____
9. ☐ _____
10. ☐ _____

Please list any additional medications and their purposes.

Have you had an allergic reaction to:

☐ Penicillin ☐ Erythromycin ☐ Tetracycline
☐ Aspirin ☐ Acetaminophen ☐ Ibuprofen ☐ Codeine ☐ Sulfa ☐ Local Anesthetic
☐ Acrylic ☐ Fluoride ☐ Food ☐ Latex ☐ Metals (Nickel, Gold, Silver) ☐ Red Dye
☐ Other: _____

Women (please check): ☐ Pregnant/ trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives?

Social Habits

Do you use tobacco in any form? ☐ YES ☐ NO

If so, what type? _____ How much/ many packs per day? _____

Do you use recreational drugs? ☐ YES ☐ NO

If so, which ones and how much? _____

Number of sodas or sweet drinks per day? _____ Number of alcoholic drinks per week? _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next visit without fail.

_____ _____

Patient/Guardian Signature Doctor Signature

_____

Relationship to Patient