Time 10:41 AM | Drs. Halpern _Halpern, P.A. | Date 7/26/2016

COLUMBIA SMILES MEDICAL FORM REVISED 2016

Patient Name: Birth Date: Date Created:

Although we primarily treat the area in and around your mouth, your mouth is a part of your entire body. Thank you.

Question	Answer	
Physician's Name and phone number?	Yes No	If yes
Have you gone abroad in the past year and where?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take or have you taken Phen-Fen or Redux. Fosamax, Boniva, Actonel or bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	If yes
Do you currently or have you ever used tobacco?	Yes No	If yes
Have you had recommended immunizations?	Yes No	If yes

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?
- ☐ had HPV vaccination?

Are you allergic or had an adverse reaction to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Ibuprofen/ Acetaminophen
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics

Question	Answer	
Other Allergies?	Yes No	If yes
Do you have a drug or alcohol dependency or use controlled substances?	Yes No	If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition	
AIDS/HIV Positive	Yes No	Alzheimer's Disease	Yes No	Anaphylaxis	Yes No
Angina	Yes No	Arthritis/Gout/Rheumatism	Yes No	Artificial Heart Valve	Yes No
Asthma	Yes No	Auto Immune Disorder	Yes No	Blood Disease	Yes No
Blood Transfusion	Yes No	Breathing Issues	Yes No	Bruise Easily	Yes No
Cancer	Yes No	Chemotherapy/ Radiation	Yes No	Cold Sores/ Fever Blisters	Yes No
Diabetes	Yes No	Epilepsy or Seizures	Yes No	Excessive Bleeding	Yes No
Excessive Thirst	Yes No	Fainting Spells/ Dizziness	Yes No	Frequent Cough	Yes No
Frequent Diarrhea	Yes No	Frequent Headaches/ Migrai	Yes No	Glaucoma	Yes No
Heart Attack/ Failure	Yes No	Heart Trouble/ Disease	Yes No	Heart Pacemaker	Yes No
Hepatitis A, B or C	Yes No	High Blood Pressure	Yes No	High Cholesterol	Yes No
Hives or Rash	Yes No	Hypoglycemia	Yes No	Kidney Dialysis	Yes No
Kidney Disease	Yes No	Liver Disease	Yes No	Low Blood Pressure	Yes No
Lung Disease	Yes No	Lyme Disease	Yes No	Neurological Disorder	Yes No
Osteoporosis	Yes No	Parathyroid/ Thyroid Disease	Yes No	Psychiatric Care	Yes No
Recent Weight Loss	Yes No	Rheumatic/ Scarlet Fever	Yes No	Sexually Transmitted Illness	Yes No
Shingles	Yes No	Sinus Trouble/ Hay Fever	Yes No	Stomach/ Intestinal Disease	Yes No
Stroke	Yes No	Swelling of Limbs	Yes No	Artificial Joint	Yes No
Tonsillitis	Yes No	Tumors or Growths	Yes No	Jaundice	Yes No

Question	Answer	
Please explain any yes answers above	☐	If yes
Have you ever had any serious illness not listed?	Yes No	If yes
Have you had a recent blood pressure reading?	Yes No	If yes

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:____________