Cameron M. Workman, DDS, P.C.

Date:_____ Referred By: Dental Insurance? **Y N**

Patient's Name:_____ SSN:_____ Birth date:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell Phone #:_____ Sex: **M F** Marital Status: **M S W D**

Preferred Method of contact: Phone call _____Text _____ Email Address: _____

Employer_____ Phone #_____ Occupation:_____
Spouse:_____ SSN:_____ Phone #:_____
Emergency Contact Person:_____ Phone #:_____ Relationship:_____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT (If other than person above)

Name of Responsible person:_____ Relationship:_____
Birth date:_____ SSN:_____ Phone #:_____
Address:_____ City:_____ State:_____ Zip:_____

Medical Health Questionnaire

Are you currently under a physician's care? YES ☐ NO ☐

Date of last physician visit: _____ Reason: _____
Name of physician: _____ Phone #: _____
Address: _____

YES NO
☐ ☐ Have there been any changes in your general health in the last year?
☐ ☐ Have you had any serious illness, operation, or been hospitalized in the past 5 years?
Explain: _____

YES NO
☐ ☐ Has your physician ever recommended that you take antibiotics prior to dental or surgical treatment?
☐ ☐ Have you had an orthopedic total joint replacement or heart valve replacement? When? _____
☐ ☐ Do you have a heart murmur or a history of rheumatic heart disease?
☐ ☐ Have you ever taken diet pills, such as Pondimin (fenfluramine), Redux (dexphenfluramine) or Fen-Phen (phentermine)? If "Yes" how long? _____
☐ ☐ Have you taken cortisone (steroids) in the last 2 years?
☐ ☐ Do you drink any type of alcohol? Type/Amount: _____ No. of years _____
☐ ☐ Do you use recreational (street) drugs? _____
☐ ☐ Do you or have you used tobacco? Type/Amount: _____ No. of years _____
☐ ☐ Have you or are you taking blood thinners?

ALLERGIES Are you allergic to any of the following?

YES NO
☐ ☐ Local anesthetics
☐ ☐ Penicillin/Antibiotics
☐ ☐ Sleeping aid medications
☐ ☐ Sulfa drugs
☐ ☐ Codeine or other narcotics

YES NO
☐ ☐ Latex
☐ ☐ Nickel
☐ ☐ Aspirin
☐ ☐ Iodine

Type of reaction: _____
Other Allergies: _____

FEMALES ONLY

YES NO
☐ ☐ Post-menopausal or post-hysterectomy?
☐ ☐ Are you pregnant? Due Date: _____
☐ ☐ Are you currently breast-feeding?
☐ ☐ Are you currently taking medication for osteoporosis?

Cameron M. Workman DDS P.C.

Current Medications (Including Prescribed, Over-the-Counter and Herbal or Natural)

Name of Medication	Dose/Day	Date Started

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

Date_____ Signature _____

YES NO

1. CARDIOVASCULAR CONDITIONS

- ☐ ☐ Angina/Chest pain/Pain on exertion
- ☐ ☐ Atherosclerosis/Hardening of the arteries
- ☐ ☐ Artificial heart valve date: _____
- ☐ ☐ Internal defibrillator date: _____
- ☐ ☐ Heart attack date: _____
- ☐ ☐ Heart murmur
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Congenital heart defect
- ☐ ☐ Mitral valve prolapse
- ☐ ☐ Bypass surgery date: _____
- ☐ ☐ Pacemaker date: _____
- ☐ ☐ Rheumatic fever or rheumatic heart disease
- ☐ ☐ Irregular heart beat

YES NO

2. RESPIRATORY CONDITIONS

- ☐ ☐ Tuberculosis
- ☐ ☐ Emphysema
- ☐ ☐ Chronic bronchitis
- ☐ ☐ Asthma
- ☐ ☐ Seasonal allergies
- ☐ ☐ Sinusitis
- ☐ ☐ Persistent cough or cough up blood

YES NO

3. GASTROINTESTINAL CONDITIONS

- ☐ ☐ Colon disorders
- ☐ ☐ Gastroesophageal reflux/Heartburn
- ☐ ☐ Ulcers
- ☐ ☐ Gallbladder trouble/stones
- ☐ ☐ Liver disease
  - o Hepatitis A B C
  - o Cirrhosis
  - o Other liver conditions

YES NO

4. ENDOCRINE CONDITIONS

- ☐ ☐ Thyroid problems: _____
- ☐ ☐ Parathyroid problems: _____
- ☐ ☐ Diabetes Type: _____
- ☐ ☐ Hypoglycemia

YES NO

5. GENITOURINARY CONDITIONS

- ☐ ☐ Kidney problems
- ☐ ☐ Dialysis
- ☐ ☐ Bladder infections

YES NO

6. SEXUALLY TRANSMITTED DISEASE

- ☐ ☐ Type: _____

YES NO

7. CANCER

- ☐ ☐ Site: _____ Type: _____
- ☐ ☐ Chemotherapy Date: _____
- ☐ ☐ Radiation/Cobalt therapy Date:_____
- ☐ ☐ Surgery Date: _____

YES NO

8. BONE & JOINT CONDITIONS

- ☐ ☐ Osteoarthritis
- ☐ ☐ Osteoporosis
- ☐ ☐ TMJ problems
- ☐ ☐ Jaw surgery
- ☐ ☐ Frequent fractures
- ☐ ☐ Rheumatoid arthritis

YES NO

9. BLOOD ABNORMALITIES

- ☐ ☐ Prolonged bleeding
- ☐ ☐ Anemia
- ☐ ☐ Sickle cell disease:_____Trait:_____
- ☐ ☐ Hemophilia Type: _____
- ☐ ☐ Blood transfusion Year: _____

YES NO

10. NEUROLOGIC CONDITIONS

- ☐ ☐ Epilepsy
- ☐ ☐ Convulsions/Seizures
- ☐ ☐ Stroke
- ☐ ☐ Neuritis
- ☐ ☐ Neuralgia/Tics
- ☐ ☐ Numbness/Paralysis
- ☐ ☐ Severe frequent headaches
  - o Migraines
  - o Repeated blackouts/Fainting
- ☐ ☐ Chronic facial pain

YES NO

11. PSYCHOLOGICAL CONDITIONS

- ☐ ☐ Depression
- ☐ ☐ Anxiety or panic disorders
- ☐ ☐ Bipolar disease
- ☐ ☐ Eating disorder, anorexia, bulimia, etc.

YES NO

12. DERMATOLOGIC CONDITIONS

- ☐ ☐ Chronic/Recurrent skin rash
- ☐ ☐ Hives
- ☐ ☐ Psoriasis
- ☐ ☐ Eczema
- ☐ ☐ Other: _____

YES NO

13. IMMUNE CONDITIONS

- ☐ ☐ AIDS or HIV infection
- ☐ ☐ Sarcoidosis
- ☐ ☐ Lupus erythematosis
- ☐ ☐ Immunosuppression
  - o drug induced: _____
  - o radiation induced: _____
  - o Other immune disease:_____

CURRENT MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever taken Fosamax, Atonal, Boniva (**Bisphosphonates**), or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?

YES NO