

Medical Information

Charles E. Moggia, D.D.S.

Name

Last _____ First _____ Middle _____ Today's Date _____

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Autoimmune disease.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid problems.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Previous infective endocarditis.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart.....	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD).....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>								
Cardiovascular disease.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Mitral valve prolapse.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, specify _____		
Damaged heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____		
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects.....	<input type="checkbox"/>	<input type="checkbox"/>				Sexually transmitted disease.....	<input type="checkbox"/>	<input type="checkbox"/>
						Excessive urination.....	<input type="checkbox"/>	<input type="checkbox"/>

Do you wear contact lenses?..... Yes No

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?..... Yes No

Date: _____ If yes, have you had any complications?.....

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's Disease?..... Yes No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia, skeletal complications resulting from Paget's Disease, multiple myeloma or metastatic cancer?..... Yes No

Date treatment began: _____

Allergies - Are you allergic to or have you had a reaction to: To all YES responses, specify a type of reaction.

Local anesthetics.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills.....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>

Do you use controlled substances (drugs)?..... Yes No

Do you use tobacco (smoking, snuff, chew, bidis)..... Yes No

If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED

WOMEN ONLY Are you: Pregnant?..... Yes No

Number of weeks: _____

Taking birth control pills or hormonal replacement?..... Yes No

Nursing?..... Yes No

NOTE: IF YOU ARE TAKING BIRTH CONTROL PILLS IT IS IMPORTANT TO UNDERSTAND THAT ANTIBIOTICS MAY INTERFERE WITH THE EFFECTIVENESS OF THE PILL. WHEN ANTIBIOTICS ARE TAKEN, ANOTHER METHOD OF BIRTH CONTROL IS RECOMMENDED FOR THE REST OF THAT CYCLE'S PACKAGE OF PILLS. CONSULT YOUR PHYSICIAN FOR FURTHER GUIDANCE.

Metals..... Yes No

Latex (rubber)..... Yes No

Iodine..... Yes No

Hay fever/seasonal..... Yes No

Other (Please List)..... Yes No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?..... YES NO

Do you have any disease, condition, or problem not listed above that you think I should know about?..... YES NO

ARE YOU TAKING OR HAVE TAKEN ANY MEDICATION OF ANY KIND DURING THE PAST YEAR? (IF YES, PLEASE LIST BELOW) YES NO

NAME	DOSE	PURPOSE OF MEDICATION

AUTHORIZATION AND RELEASE
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X
Signature of patient (or parent if patient is a minor) _____ Date _____