

MEDICAL

Mark Forrest. D.M.D.
 Periodontics & Implant Surgery

Last name: (print) _____ Date: _____

First name: _____ Title: Mr. Mrs. Miss Ms. Dr.

Date of birth: _____ Marital status: Married Single Widowed Divorced

Street: _____ City: _____ Zip code: _____

Social security #: _____ - _____ - _____ Email: _____

Home phone: _____ Cell phone: _____ Business phone: _____

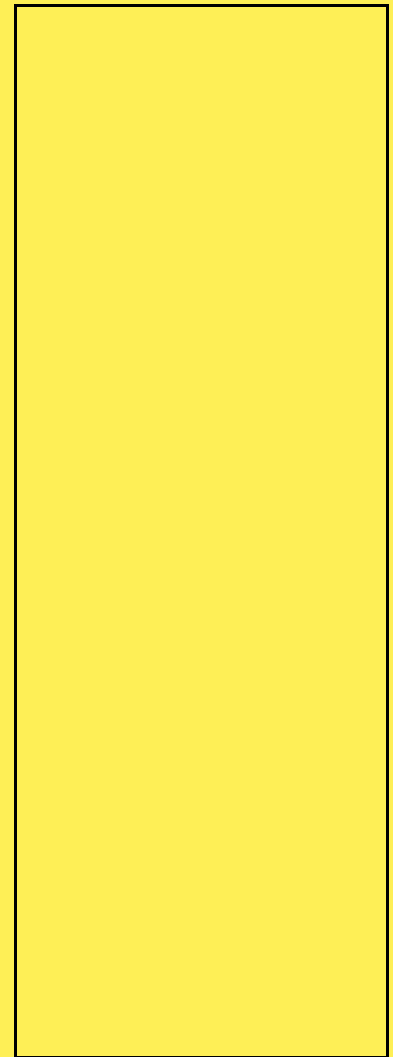
Best phone number to reach you: Home Cell Business

Employed by: _____ Spouse's name: _____ Spouse's work phone: _____

Spouse employed by: _____ Nearest relative: _____ Phone: _____

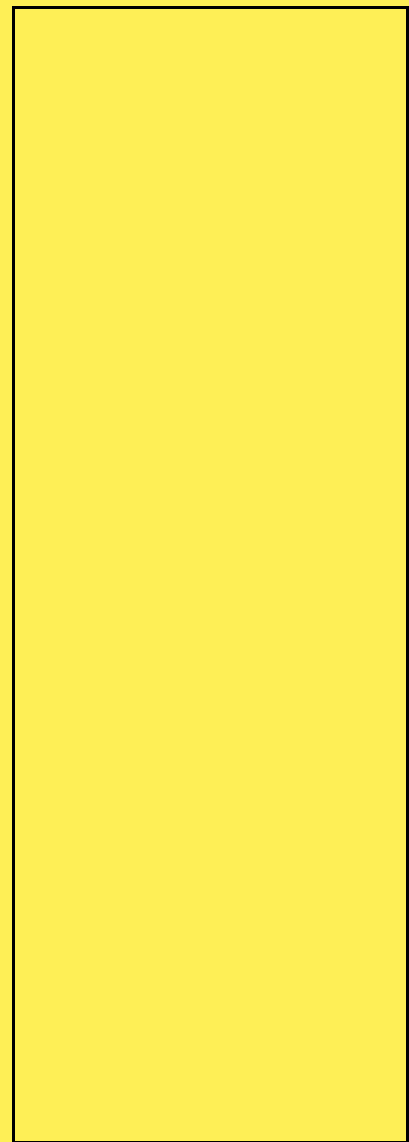
Referred by: _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you under a physician's care at present?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any type of health problem?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, if yes please specify | | |
| _____ | | |
| _____ | | |
| 3. Are you taking any medicine or vitamins now?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list all: | | |
| _____ | | |
| _____ | | |
| 4. Have you had any seriously illness, or been hospitalized in the last 5 years ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any of the following? | | |
| A heart valve replacement..... | <input type="checkbox"/> | <input type="checkbox"/> |
| A history of infective endocarditis (IE) | <input type="checkbox"/> | <input type="checkbox"/> |
| A serious congenital heart condition | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart trouble..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Positive HIV or AIDS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| A joint replacement (hip, knee, finger, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis, jaundice, or liver disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Dry mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had an allergic reaction to any of the following? | | |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin | <input type="checkbox"/> | <input type="checkbox"/> |
| Tetracycline..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other medicine: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex | <input type="checkbox"/> | <input type="checkbox"/> |



(over)

- | | Yes | No |
|--|--------------------------|--------------------------|
| 7. Have you ever experienced an unusual reaction to a dental injection (novocaine)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had an injury to your face or jaws? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had surgery for a tumor, growth or skin disease?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had radiation treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you short of breath on mild exertion?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have chest pain on exertion?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do your ankles swell? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have your ever had prolonged bleeding following a cut or extraction of a tooth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you smoke cigarettes? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes: How many packs/day: _____ | | |
| How many years have you smoked? _____ | | |
| 16. If you do not smoke cigarettes now, did you ever smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes: How many packs/day: _____ | | |
| How many years did you smoke? _____ | | |
| When did you stop smoking? _____ | | |
| 17. Do you smoke cigars or a pipe, or use snuff or chewing tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. How many times per week do you drink alcoholic beverages? | | |
| 19. Has any blood relative ever had diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Has any blood relative ever had periodontal (gum) disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have any disease, condition or problem not listed above that you think I should know about? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please specify _____ | | |
| 22. Is there anything that you would like to discuss with the doctor in <i>private</i> ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Are you presently in a relationship with a person who threatens you or physically hurts you?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Women only | | |
| 24. Do you have osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you take any medication for osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you reached menopause?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you take hormone replacement therapy or birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |



Date of last physical exam: _____

Findings: _____

Physicians (Medical doctors)

Name: _____ Phone: _____

Address: _____ City/State: _____ Zip code: _____

Name: _____ Phone: _____

Address: _____ City/State: _____ Zip code: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold Dr. Forrest, or any member of his staff, responsible for any actions they take, or do not take, because of errors or omissions that I made in the completion of this form.

Signature: _____ **Date:** _____
(patient or relative representative)