goldstein garber & salama, llc
600 Galleria Parkway, suite 800, Atlanta, GA 30339
Phone: 404-261-4941 Fax: 404-261-4946

date _____

MEDICAL STATUS FORM

Name: _____ Birth date _____
Address: _____ Sex ___M ___F
_____

Phones: home: _____
work: _____ cell: _____
email: _____

The dentistry you receive has an important interrelationship with the health problems that you may have, or medications you are taking. It is imperative that you provide the following information to help us treat you as effectively and safely as possible.

Please initial that you read this paragraph: _____

Are you under a physician's care now?	( )yes ( ) no	If yes, please explain: Dr. Name: Address: Telephone Number: Date of last physical exam:
Have you ever been hospitalized or had a major operation in the past five years?	( )yes ( )no	If yes, please explain:
Have you ever had a serious head or neck injury?	( )yes ( )no	If yes, please explain:
Are you taking **any** prescription or non-prescription medications, pills, herbal supplements, aspirin, ibuprophen, vitamin E or drugs?	( )yes ( )no	If yes, please list and explain: _____ _____ _____
Are you taking or have you taken bisphosphonate for osteoporosis: such as Actonel, Boniva, Fosamax, Zometa or Aredia?	( )yes ( )no	If yes, please explain:
Have you ever been advised to take pre-medication for dental visits?	( )yes ( )no	If yes, please explain:
Have you ever had a lesion biopsied or removed from the mouth or lips?	( )yes ( )no	If yes, please explain:
Are you on a special diet?	( )yes ( )no	If yes, please explain:
Do you smoke or use tobacco?	( )yes ( )no	If yes, how much? How long?
Do you use controlled substances?	( )yes ( )no	If yes, please explain:
Do you consume alcohol?	( )yes ( )no	If yes, please explain:
Has anyone told you that you snore?	( )yes ( )no	

WOMEN:	Are you pregnant or trying to get pregnant?	( ) Yes	( ) No
	Taking oral contraceptives?	( ) Yes	( ) No
	Nursing?	( ) Yes	( ) No

DA/RDH Initials:_____
Dr. Initials:_____

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐Tetracycline ☐ Erythromycin ☐ Codeine

☐ Acrylic ☐ Metal ☐ Sulfa ☐ Local Anesthetics ☐ Latex

☐ Other: _____ ☐ No Known Allergies

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

AIDS/HIV Positive	☐ yes ☐ no	Implants-Hip/Breast/knee/tooth	☐ yes ☐ no
Allergies	☐ yes ☐ no	HPV (Human Papilloma Virus)	☐ yes ☐ no
Alzheimer's Disease	☐ yes ☐ no	High Blood Pressure	☐ yes ☐ no
Anaphylaxis	☐ yes ☐ no	Hives or Rash	☐ yes ☐ no
Anemia	☐ yes ☐ no	Hypoglycemia	☐ yes ☐ no
Angina/Chest Pains	☐ yes ☐ no	Irregular Heartbeat	☐ yes ☐ no
Arthritis/Gout	☐ yes ☐ no	Kidney Problems	☐ yes ☐ no
Artificial Heart Valve	☐ yes ☐ no	Leukemia	☐ yes ☐ no
Artificial Joint	☐ yes ☐ no	Liver Disease	☐ yes ☐ no
Asthma	☐ yes ☐ no	Low Blood Pressure	☐ yes ☐ no
Blood Disease	☐ yes ☐ no	Lung Disease	☐ yes ☐ no
Blood Transfusion	☐ yes ☐ no	Mitral Valve Prolapse	☐ yes ☐ no
Bruise Easily	☐ yes ☐ no	Osteoporosis	☐ yes ☐ no
Cancer	☐ yes ☐ no	Periodontal "gum" Disease	☐ yes ☐ no
Chemotherapy	☐ yes ☐ no	Psychiatric Care	☐ yes ☐ no
Celiac Disease	☐ yes ☐ no	Radiation Treatments	☐ yes ☐ no
Congenital Heart Disorder	☐ yes ☐ no	Recent Weight Loss	☐ yes ☐ no
Convulsions	☐ yes ☐ no	Renal Dialysis	☐ yes ☐ no
Cortisone Medicine	☐ yes ☐ no	Rheumatic Fever	☐ yes ☐ no
Diabetes	☐ yes ☐ no	Rheumatism	☐ yes ☐ no
Drug Addiction	☐ yes ☐ no	Scarlet Fever	☐ yes ☐ no
Eating Disorder (Bulimia and/or Anorexia)	☐ yes ☐ no	Stomach/Intestinal Disease/Ulcers	☐ yes ☐ no
Emphysema	☐ yes ☐ no	Shortness of Breath	☐ yes ☐ no
Epilepsy or Seizures	☐ yes ☐ no	Sickle Cell Disease	☐ yes ☐ no
Excessive Bleeding	☐ yes ☐ no	Sinus Trouble	☐ yes ☐ no
Excessive Thirst	☐ yes ☐ no	Special Diet	☐ yes ☐ no
Fainting Spells/Dizziness	☐ yes ☐ no	Spina Bifida	☐ yes ☐ no
Frequent Cough	☐ yes ☐ no	Shingles/Herpes/Cold sores/Fever blisters	☐ yes ☐ no
Frequent Diarrhea	☐ yes ☐ no	Stroke	☐ yes ☐ no
Frequent Headaches	☐ yes ☐ no	Swelling of Limbs	☐ yes ☐ no
Glaucoma	☐ yes ☐ no	Thyroid Condition	☐ yes ☐ no
Heart Attack/Failure	☐ yes ☐ no	Tonsilitis	☐ yes ☐ no
Heart Murmur	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no
Heart Pace Maker	☐ yes ☐ no	Tumors or Growths	☐ yes ☐ no
Heart Trouble/Disease	☐ yes ☐ no	Venereal Disease	☐ yes ☐ no
Hemophilia	☐ yes ☐ no	Yellow Jaundice	☐ yes ☐ no
Hepatitis A, B, C, D, or E	☐ yes ☐ no	Contact Lenses	☐ yes ☐ no

Have you ever had any serious illness not listed above? ( ) Yes ( ) No

If yes, please explain: _____

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 _____ date_____

DA/RDH Initials:_____

Dr. Initials:_____