

Canandaigua Oral Surgery, PC 500 North Main Street Canandaigua, New York 14424

Nathan T Cary, DDS Phillip G Cary, DDS

Personal Medical and Dental History

Patient Name:	Date of Birth:	Age:	Male	Female

Referred by:_____

Medications and Supplements: please list all medications and supplements you take:

medication/supplement	dosage	frequency	used for:

Are you allergic to any medications, foods, latex, or metals? Yes No (please list allergies below)

Please check any of the following medical conditions you have, had, or are presently treated for:

heart disease	diabetes	liver disease	depression/anxiety
heart attack	stomach ulcers/acid reflux	kidney disease	alcohol/drug abuse
heart surgery	hepatitis	organ transplant	psychiatric disorder
angina	anemia	thyroid disease	alzheimers/dementia
irregular pulse	bleeding disorder	asthma	sinus disease
pacemaker	blood thinners	emphysema/bronchitis	environmental allergies
heart murmur	seizures/epilepsy	bowel disease	hearing/speech problem
rheumatic fever	migraine	tuberculosis	autoimmune disorder
high blood pressure	sleep apnea	HIV/AIDS	glaucoma
stroke	cancer	syncope (fainting)	arthritis

Do you have any artificial joints, heart valve(s) replacement, or vascular grafts?	yes	no
If yes, type:		
Have you been advised by your physician to take antibiotics prior to dental treatment?	yes	no
Have you ever received radiation therapy of the head or neck?	yes	no
Have you ever received chemotherapy?	yes	no

If you have or have had cancer, please indicate type and status:

Date: Canandaigua Oral Surgerv. PC 500 North Main Street Canandaigua.		
Patient (or adult guardian/POA) signature:		
the above information is true and accurate Reviewed:		
Please list any other medical conditions or personal concerns you feel we should be av	ware of	:
What is your current height? feet and inches What is your current weight? pounds		
Nomen: Are you pregnant or breast feeding?	yes	no
Do you have a known or suspect TMJ (jaw joint) disorder? Have you taken steroid medications within the past two years?	yes yes	no no
Do you grind or clench your teeth?	yes	no
type:	yes	no
amount: daily occasionally rarely Do you use any recreational drugs?	yes	no
Do you drink alcohol? type: beer wine liquor	yes	no
Have you used tobacco in the past? When did you quit?	yes	no
Do you use tobacco? type: cigarettes cigars snuff/chewing tobacco amount: (packs per day): duration: (years):	yes	no
tometa, boniva, reclast, evista, prolia)? f yes, for how long (years)? f no longer using one of these medications, how long ago did you stop using it?	yes	no
lave you in the past, or are you currently using a bone strengthening medication (fosa	may a	rodia
Type: Status: cured remission undergoing treatment now.		

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