Jon D. Celino, DDS

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Fleur de Lis Dental Care

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Patient's Name:_____ Date of Birth:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you receive. Thank you for answering the following questions.

Please check one:
Do you have a primary doctor?____Yes____No
If yes: Dr.'s Name:_____
Have you had any major operations?___Yes___No
If yes: Please list:_____
Are you currently taking any medications?___Yes___No
If yes: Please list:_____
Do you,or have you, used tobacco?___Yes___No
Are you on a special diet?___Yes___No
Do you use controlled substances?___Yes___No

Women:
Are you taking birth control pills? Yes No What?_____
Are you: Pregnant?___Yes___No If Yes, _____Months
Currently trying to get pregnant?___Yes___No
Nursing?___Yes___No

Allergies:
Are you allergic to any of the following: Please check all that apply:
____Aspirin ____Penicillin ____Codeine ____Acrylic ____Metal ____Latex
____Local Anesthetics ____Other:_____

Health Conditions: Current or In the Past: Please check all that apply:

___Allergies
___Arthritis
___Artificial Joint
___Blood Disorders
___Calcium Supplements
___Cancer
___Cardiovascular Disease
___Chemotherapy or Radiation Treatment
___Chest Pain
___Cold Sores or Herpes Virus
___Coronary Artery Disease
___Diabetes
___Dizziness
___Excessive Bleeding
___Excessive Thirst
___Eye Sight Impaired
___Frequent Diarrhea
___Frequent Headaches
___Head Injury
___Hearing Impaired
___Heart Disease or Heart Attack
___Heart Graft or Valve Replacement
___Heart Murmur
___Hepatitis
___Heparin Therapy
___High Blood Pressure
___HIV Or AIDS
___Jaundice
___Kidney Disease
___Liver Disease
___Mental Disorders
___Nervous Disorders
___Pacemaker
___Recent Weight Loss
___Respiratory Problems
___Seizure Disorders
___Shingles
___Sinus Problems
___Stent Replacement
___Stomach Problems
___Stroke
___Thyroid Disease
___Tonsillitis
___Tuberculosis
___Tumors
___Ulcers
___Use of Protease Inhibitors
___Use of Biphosphonates
___Use of Anti-Coagulants (Blood Thinners)
___Venereal Disease
___Vitamin Deficiency
___Other:_____
_____

Comments:_____
_____
_____

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 patients) health. It is my responsibility to inform the dental office of any changes in my medical status

Signature:_____Date:_____