Time 11:00 AM | New Image Dentistry On Vinton Street | Date 4/5/2017

Medical Questionnaire for Dental Treatment

Patient Name: | Birth Date: | Date Created:

Welcome to New Image Dentistry. What is the reason for your first visit? (Cual es la razon de su visita ?) Comment

Physician's Name (Nombre de su Doctor) Comment

Have you ever been hospitalized or had a major operation? (A estado hospitalizado o tenido una operacion quirurjica?) ◯ Yes ◯ No If yes

List any medications you are currently taking. (Lista de medicamentos que esta tomando) Comment

Are you allergic to any of the following? (Tiene una alergia a una de los siguiente?)

- ☐ Aspirin (Aspirina)
- ☐ Penicillin (Penicillina)
- ☐ Codeine (Codeina)
- ☐ Sulfa Drugs (Drogas Sulfamidas)
- ☐ Latex (Latex)
- ☐ Metal (Metal)
- ☐ Local Anesthetics (Anestesia local)
- ☐ Other (Otra alergia)

What are your symptoms to the above allergy? (Cuales son los sintomas a las alergias?)

- ☐ Breathing Problems (Problemas Respirator
- ☐ Hives/Rash (Urticaria/Erupcion)
- ☐ Upset Stomach (Dolor de estomago)
- ☐ Other (Otro Sintoma)

Women (Mujer): Are you... (Usted esta...)

- ☐ Pregnant? (Embarazada?)
- ☐ Trying to get pregnant? (Tratando De Quedar Embarazada?)
- ☐ Nursing? (Dando Pecho?)
- ☐ Taking oral or medical contraceptives? (Tomando anticonceptivos?)

If yes, What is your expected due date? (Si su respuesta es si, cual es la fecha estimada para dar a luz?)

Have you ever taken any medication for Osteoporosis? (A tomado algun medicamento para la Osteoporosis?) ◯ Yes ◯ No If yes

Do you have, or have you had, any of the following? (A tenido o tiene cualquiera de los siguiente?)

AIDS/HIV Positive (Sida/VIH Positivo) ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Artificial Joint (Dolor en las articulac ◯ Yes ◯ No	Bells Palsy (Paralisis Bell) ◯ Yes ◯ No
Cold Sores/ Fever Blisters (herpes labia ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Drug Addiction/Alcoholism (Addiccion a dr ◯ Yes ◯ No	Epilepsy/Seizures (Epilepsia/Convulsione ◯ Yes ◯ No
Fainting Spells/Dizziness (Desmayos/mare ◯ Yes ◯ No	Frequent Headaches (Dolor de cabeza freq ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Hepatitis B ◯ Yes ◯ No
Hepatitis C ◯ Yes ◯ No	High Blood Pressure (Alta presion) ◯ Yes ◯ No	Low Blood Pressure (Baja presion)) ◯ Yes ◯ No	Stroke (Ataque Cerebral) ◯ Yes ◯ No
Thyroid Disorder (Trastorno de la Tiroid ◯ Yes ◯ No	Trigeminal Neuralgia (Neuralgia Trigemin ◯ Yes ◯ No	Kidney Disorder (Desorden del rinon) ◯ Yes ◯ No	Liver Disorder (Desorden del higado) ◯ Yes ◯ No
Cancer ◯ Yes ◯ No			

Heart Problems (Problemas del Corazon):

Pacemaker (Marcapasos para el corazon) ◯ Yes ◯ No	Mitral valve prolapse (Prolapso de valvu ◯ Yes ◯ No	Irregular Heartbeat (Palpito irregular de ◯ Yes ◯ No	Heart Attack/Failure (Infarto Cardiaco/In ◯ Yes ◯ No
Cardiac Bypass/Stents (Derivacion del cor ◯ Yes ◯ No	Valve Replacement (Reemplazo de valvula) ◯ Yes ◯ No	Other (Otro) ◯ Yes ◯ No	

Have you ever had a major heart surgery? (Ha tenido cirugia del corazon?) ◯ Yes ◯ No If yes

Lung Conditions / Breathing Problems (Condiciones del pulmon/problemas respiratorios)

Asthma (Asma) ◯ Yes ◯ No	Emphysema (Enfisema) ◯ Yes ◯ No	COPD (Enfermedad Pulmonar Obstructiva Cronica) ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No

Are you undergoing, or have you ever had, any of the following Cancer treatments? (Tiene o ha tenido qualquiera de los siguients tratamientos de cancer?)

Chemotherapy (Chemoterapia) ◯ Yes ◯ No	Radiation (Radiacion) ◯ Yes ◯ No	Surgery/Reconstruction (cirujia/reconstrucion) ◯ Yes ◯ No	Other (Otro) ◯ Yes ◯ No

Do you use: (UD usa:

Smokeless Tobacco (Tabacco sin humo) ◯ Yes ◯ No	Cigarettes (Cigarros) ◯ Yes ◯ No	Any controlled substance (Substancias ◯ Yes ◯ No

Vision Disorder: (Desorden de vision)

Glaucoma ◯ Yes ◯ No	Cataracts (Catarata) ◯ Yes ◯ No	Diabetic Retinopathy (Retinopatia Diabetica) ◯ Yes ◯ No
Blind (Ciego) ◯ Yes ◯ No	Macular Degeneration (Degeneracion Macular) ◯ Yes ◯ No	

Hearing Disorder: (Desorden de oir)

Deaf (Sordo) ◯ Yes ◯ No	Hard of hearing (Mal de oido) ◯ Yes ◯ No	Do you wear hearing aids? (Usa audifonos para oir?) ◯ Yes ◯ No

Mental Health Conditions: (Condiciones Mentales)

Bipolar Disorder (Desorden bipolar) ◯ Yes ◯ No	Depression (Depresion) ◯ Yes ◯ No	Anxiety (Ansiedad) ◯ Yes ◯ No	Schizophrenia (Esquizofrenia) ◯ Yes ◯ No

Congenital Disorders: (Desordenes Congenitales)

Spina Bifida (Espina Bifida) ◯ Yes ◯ No	Cerebral Palsy (Paralisis cerebral) ◯ Yes ◯ No	Down Syndrome (Sindrome de down) ◯ Yes ◯ No
Muscular Dystrophy (Distrofia Muscular) ◯ Yes ◯ No	Mental or Physical challenges (Retrasos mentales o physicos) ◯ Yes ◯ No	Aspergers / Autism (Aspergers/Autismo) ◯ Yes ◯ No

Have you ever had any serious illness not listed above? (Ha tenido cualquier otra enfermedad seria?) ◯ Yes ◯ No If yes

Signature

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. (A lo mejor de mi concentimiento, las preguntas en este formulario han sido contestadas con exactitud. Entiendo que dar informacion falsa puede se peligroso para mi salud (o la del paciente). Es mi responsabilidad de informarle a mi oficina dental de cualquier cambio medico.

Signature of Patient, Parent or Guardian (Firma de paciente, Padre o Guardian):

X

Date:_____