Zhukovsky Dental Clinic

1812 Quentin Rd. Ste M1
Brooklyn, NY 11229

Medical History

PATIENT DETAILS

First Name* Middle Name Last Name *

Date of Birth *

Gender ○Male ○Female ○Prefer not to say Marital Status

HEALTH HISTORY

Are you currently under the care of a physician? ○Yes ○No

Physician Name:
Physician Phone Number:

Have you ever been hospitalized or had a major operation? ○Yes ○No

If yes, please explain:

How would you rate your physical health? (Please circle one)

Good Fair Poor

Have you undergone placement of any metal rods, pins, or implants? ○Yes ○No

If yes, please explain:

Have you ever had a serious head or neck injury? ○Yes ○No

If yes, please explain:

Do you take, or have you taken, PhenFen or Redux? ○Yes ○No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○Yes ○No

If yes, please explain:

Do you use tobacco in any form? ○Yes ○No

Zhukovsky Dental Clinic

1812 Quentin Rd. Ste M1
Brooklyn, NY 11229

Do you use controlled substances? ○Yes ○No

If yes, please explain:

Are you on a special diet? * ○Yes ○No

If yes, please explain:

MEDICAL HISTORY

Do you have allergies to any of the following?

- ▫ Aspirin
- ▫ Acrylic
- ▫ Codeine
- ▫ Latex
- ▫ Local Anesthetics
- ▫ Metal
- ▫ Penicillin
- ▫ Sulfa Drugs
- ▫ Other:

If you answered "Other" please specify/explain:

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

- ▫ Anemia
- ▫ Artificial Joints
- ▫ Blood Disease
- ▫ Diabetes
- ▫ Epilepsy
- ▫ Fainting Glaucoma
- ▫ Heart Disease
- ▫ High Blood Pressure
- ▫ Jaundice
- ▫ Liver Disease
- ▫ Nervous Disorders
- ▫ Arthritis
- ▫ Asthma
- ▫ Cancer
- ▫ Dizziness
- ▫ Excessive Bleeding
- ▫ Head Injuries
- ▫ Hepatitis
- ▫ HIV
- ▫ Kidney Disease
- ▫ Mental Disorders
- ▫ Pacemaker

- ▫ Pregnancy
- ▫ Respiratory Problems
- ▫ Rheumatism
- ▫ Stomach Problems
- ▫ Tuberculosis
- ▫ Ulcers
- ▫ Other
- ▫ Radiation Treatment
- ▫ Rheumatic Fever
- ▫ Sinus Problems
- ▫ Stroke
- ▫ Tumors
- ▫ Venereal Disease

If you answered "Other" please specify/explain:

Are you currently taking any of the following medications?

- ▫ Aspirin
- ▫ Penicillin
- ▫ Codeine
- ▫ Pre-Med - Amox
- ▫ Pre-Med - Clind
- ▫ Pre-Med - Other

If you answered "Other" please specify/explain:

Patient Signature: _____x Date: ____/____/_____