THE DENTIST, Dr. Jeffrey C. Kirian, DDS Medical History(Copy)

Patient Name: Birth Date: Date Created:

The health of your mouth and oral cavity directly affects the health of your entire body. The health of your body directly affects your oral health. Please answer the health questionnaire completely

Who is your primary care physician? Are you under any physician's care currently? (Name and phone number)	◯ Yes ◯ No	If yes	
Date of last physical	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications (prescribed or OTC) or supplements?	◯ Yes ◯ No	If yes	
Do you require an antibiotic pre-medication for dental treatment:? If so, why and for what duration?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
COVID Vaccine (Most recent administration date-approximately)	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No	If yes	
Do you use tobacco/marijuana/vape?	◯ Yes ◯ No	If yes	
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Have you had regular check-ups? If yes, date of last exam?	◯ Yes ◯ No	If yes	
Do you brush your teeth? If yes, how often?	◯ Yes ◯ No	If yes	
Do you floss? If yes, how often	◯ Yes ◯ No	If yes	
Do you use mouthwash? If yes, what kind?	◯ Yes ◯ No	If yes	
Do you have bad breath or taste?	◯ Yes ◯ No		
Do your gums bleed when you brush your teeth?	◯ Yes ◯ No		
Do you feel you need much dental treatment?	◯ Yes ◯ No		
Has fear ever prevented you from seeking dental treatment?	◯ Yes ◯ No		
Are you happy with the appearance of your teeth?	◯ Yes ◯ No		

Is there anything you would like to change? Color Shape Whitening Straighter

Do you have any other concerns?

Current Health

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

Angina/Chest Pain ◯ Yes ◯ No	Atrial Fibrillation (A-Fib) ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No
Endocarditis ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Heart Disease ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No
High Cholesterol ◯ Yes ◯ No	Hypertension (High BP) ◯ Yes ◯ No	Hypotension (Low BP) ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No
Mitral Valve Prolapse ◯ Yes ◯ No	Pacemaker ◯ Yes ◯ No	Stroke/TIA ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No

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

Artificial Joint ◯ Yes ◯ No	Back Problems/Pain ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No	

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

Anemia ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No
Hemophilia/Clot Disorder ◯ Yes ◯ No	Sickle Cell Anemia ◯ Yes ◯ No		

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

Asthma ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No	COPD ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No
Frequent Cough ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Sinus Problems ◯ Yes ◯ No
Sleep Apnea ◯ Yes ◯ No	Sleep Disorder Breathing ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No

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

Acid Reflux/GERD ◯ Yes ◯ No	Diabetes Type 1 ◯ Yes ◯ No	Diabetes Type 2 ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No
Frequent Diarrhea ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Insulin Resistance ◯ Yes ◯ No	Kidney Failure ◯ Yes ◯ No
Kidney Stones ◯ Yes ◯ No	Liver Disease (Cirrhosis) ◯ Yes ◯ No	Lower GI/Bowel Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Upper GI/Stomach Disease ◯ Yes ◯ No			

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

Anaphylaxis ◯ Yes ◯ No	Arthritis (Osteo) ◯ Yes ◯ No	Arthritis (Rheuamatoid) ◯ Yes ◯ No	Autoimmune Disease ◯ Yes ◯ No
Gout ◯ Yes ◯ No	Hives/Rash ◯ Yes ◯ No	Hyperthyroidism (High) ◯ Yes ◯ No	Hypothyroidism (Low) ◯ Yes ◯ No
Osteoporosis/Osteopenia ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No		

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

AIDS/HIV Positive ◯ Yes ◯ No	Alzheimer's/Dementia ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Chemotherapy/Radiation ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Depression/Anxiety ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Eating Disorder ◯ Yes ◯ No
Fainting/Vertigo ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No
Hepatitis B ◯ Yes ◯ No	Hepatitis C ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	HPV ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No	Sensory Disorder ◯ Yes ◯ No
Shingles ◯ Yes ◯ No	Tumors/Growths ◯ Yes ◯ No	Venereal Disease/STD ◯ Yes ◯ No	

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

Signature of Patient, Parent or Guardian:

X

Date:_____

Routine Treatment-Local Anesthetic Injections-What You Should Know

I understand, from time to time, my treatment with Dr. Kirian may include routine procedures such as fillings, crowns, bridges, dentures, veneers, periodontal scaling and root planing.

I understand these procedures are not invasive and carry very little risk.

I also understand these routine procedures are generally very successful.

However, I understand that each patient is different and responds to treatment differently.

As such, in limited instances, routine treatment may not be successful and other treatment options may be necessary.

In addition, I am aware these routine treatments may require the injection of local anesthetic for my comfort during the procedure.

I understand local anesthetic injections carry a small risk for infection.

I further understand the biology of every patient is different and discomfort from a local anesthetic injection may linger for a longer period of time in one patient than another.

I agree to advise Dr. Kirian anytime the injection site continues to be uncomfortable after treatment.

I also understand local anesthetics (articane, benzocaine, carbocaine, lidocaine, mepivicaine, etc.) contain epinephrine which assists the effectiveness and longevity of the anesthetic.

However, epinephrine can cause increased heart rates and, in more sensitive patients, cause mild anxiety.

I also understand some patients are allergic to epinephrine and, if I have such an allergy, I have advised Dr. Kirian.

I understand the above risks and benefits to local anesthetic injections and I consent to the use of local anesthetic injections as may be appropriate throughout my care.

Signature of Patient, Parent or Guardian:

X

Date:_____