SAIDI DENTAL GROUP
Dr. S. Masoud Saidi Inc.
#201, 6351 197th Street
Langley, BC V2Y 1X8
604-539-9374

PLEASE PRINT

MEDICAL HISTORY

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ ○ Male ○ Female
DD / MM / YYYY

Medical Alert: _____ Premedication: _____ Allergies: _____

Are you in general good health? ○ Yes ○ No

Has there been any change in your general health in the past year? ○ Yes ○ No

Have you visited a medical doctor or been hospitalized during the past two years? ○ Yes ○ No

If yes, please explain:

_____

Physician's Name: Dr. _____ Phone #: _____ Last Visit: _____
DD / MM / YYYY

Have you taken any medication or drugs during the past two years? (including self prescribed vitamins, supplements or Aspirin, naturopathic prescribed or non-prescribed medications): ○ Yes ○ No

If yes, please list:

_____

If you have ever been treated in the past **OR** are currently being treated with Bisphosphonate drugs, there may be a risk of complications affecting the jaw bones. Complications may develop spontaneously but dental procedures that cause trauma to the jaw bone (such as dental extractions, surgery, implants) may also pose a risk.

The tables below list examples of oral and i.v. Bisphosphonates:

Orally Administered Bisphosphonates

Brand Name	Manufacturer	Generic Name
Actonel	Procter & Gamble Pharmaceuticals	risedronate
Boniva	Roche Laboratories	ibandronate
Fosamax	Merck & Co.	alendronate
Fosamax Plus D	Merck & Co.	alendronate
Skelid	Sanofi Pharmaceuticals	tiludronate
Didronel	Procter & Gamble Pharmaceuticals	etidronate

Intravenously Administered Bisphosphonates

Brand Name	Manufacturer	Generic Name
Aredia	Novartis	pamidronate
Zometa	Novartis	zolendronic acid
Bonefos	Schering AG	clodronate

Have you ever taken any oral or injection Bisphosphonate medications? ○ Yes ○ No

Have you ever had Closterium Deficile (C-Deficile) infection? ○ Yes ○ No

Please list your hospitalization history:

Have you ever had any injury or surgery in your head and neck area (mouth, jaw, face)? ○ Yes ○ No

Are you alcohol and/or drug dependent? ○ Yes ○ No

Do you smoke or have smoking substitute patches, gums, pills, etc.? ○ Yes ○ No

Have you gained or lost more than 10 pounds (5 kilograms) in the past twelve months? ○ Yes ○ No

Do you have any bleeding disorders? ○ Yes ○ No

Do you bleed excessively from a cut or bruise easily? ○ Yes ○ No

Do you ever experience shortness of breath or chest pain when taking a walk or climbing stairs? ○ Yes ○ No

Do your hand and or feet/ankles swell? ○ Yes ○ No

Do you use extra pillows to sleep? ○ Yes ○ No

Are you aware of having an allergic (or adverse reaction) to any medication or substance? ○ Yes ○ No

If yes, please list:

PLEASE STATE YES OR NO TO THE FOLLOWING

Heart (Surgery, Attack, Disease)	○ Yes	○ No	Chest Pain	○ Yes	○ No
Congenital Heart Disease	○ Yes	○ No	Heart Murmur	○ Yes	○ No
Mitral Valve Prolapse	○ Yes	○ No	High/Low Blood Pressure	○ Yes	○ No
Artificial Heart Valve	○ Yes	○ No	Heart Pace Maker	○ Yes	○ No
Rheumatic Fever	○ Yes	○ No	Swollen Ankles, Feet or Hands	○ Yes	○ No
Shortness of Breath	○ Yes	○ No	Circulation problems	○ Yes	○ No
Asthmatic Attack Requiring Visit to Emergency	○ Yes	○ No	Asthma	○ Yes	○ No
Hay Fever	○ Yes	○ No	Allergies or Hives	○ Yes	○ No
Latex Sensitivity	○ Yes	○ No	Food Allergies	○ Yes	○ No
Urinate More Than Six Times a Day	○ Yes	○ No	Diabetes (Type I or II)	○ Yes	○ No
Thirsty Very Often/Dry Mouth	○ Yes	○ No	Thyroid Problems (Hypo or Hyper)	○ Yes	○ No
Arthritis/Rheumatism	○ Yes	○ No	Stroke	○ Yes	○ No
Diet (Restricted/Special)	○ Yes	○ No	Artificial Joints (Hip,Knee, etc.)	○ Yes	○ No
Kidney Trouble	○ Yes	○ No	Ulcers	○ Yes	○ No
Glaucoma	○ Yes	○ No	Contact Lenses	○ Yes	○ No

Emphysema	○ Yes	○ No	Chronic Cough or Cold	○ Yes	○ No
Tuberculosis (You or Family History)	○ Yes	○ No	Lung Disease	○ Yes	○ No
Bronchitis	○ Yes	○ No	Cancer	○ Yes	○ No
Radiation Therapy	○ Yes	○ No	Chemotherapy	○ Yes	○ No
Tumors	○ Yes	○ No	Psychiatric/Psychological Disorder	○ Yes	○ No
Hepatitis (A, B, AB, C)	○ Yes	○ No	AIDS	○ Yes	○ No
HIV Positive	○ Yes	○ No	Anemia	○ Yes	○ No
Blood Transfusion	○ Yes	○ No	Hemophilia	○ Yes	○ No
Sickle Cell Disease	○ Yes	○ No	Bruise Easily	○ Yes	○ No
Bleeding Problems/Disorders	○ Yes	○ No	Liver Disease	○ Yes	○ No
Yellow Jaundice	○ Yes	○ No	Paget's Disease	○ Yes	○ No
Neurological Disorders	○ Yes	○ No	Epilepsy or Seizures	○ Yes	○ No
Fainting or Dizzy Spells	○ Yes	○ No	Nervous/Anxious	○ Yes	○ No
Cortisone/Steroid	○ Yes	○ No	Venereal Disease	○ Yes	○ No
Glandular Disease	○ Yes	○ No	Hormonal Disease	○ Yes	○ No
Sinusitis/ Sinus Problems	○ Yes	○ No	Organ or Medical Transplant	○ Yes	○ No
Vomited Blood	○ Yes	○ No	Sleep Apnea or Moderate Snoring	○ Yes	○ No

FOR OUR FEMALE PATIENTS

Are you pregnant? ◉ Yes ○ No

If yes, when is the expected birth date? _____
DD / MM / YYYY

Are you planning on becoming pregnant in the future? ◉ Yes ○ No

Are you taking Birth Control Pills or do you plan to take any in the future? ◉ Yes ○ No

If yes, please read and initial the following:

Antibiotics can affect the absorption of birth control pills from stomach, causing them to be ineffective. If you are using birth control pills and have received a prescription for antibiotics, you should use other birth control measures while taking the antibiotics. _____

Do you currently have, or have had in the past any disease, condition or problem not listed above? ○ Yes ○ No

If yes, please explain:

Is there anything else about your health we should be made aware of? ○ Yes ○ No

If yes, please explain:

Do you wish to speak to the Doctor privately about any problem or medical condition? ○ Yes ○ No

I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify you of any change in my health or medication prior to receiving dental treatment.

Signature: _____ Date: _____

Patient / Patient Guardian DD / MM / YYYY

PLEASE PRINT OUT THIS FORM ONCE COMPLETED OR YOU CAN SUBMIT TO US ELECTRONICALLY

SUBMIT NOW