ZCYW PERIO IMPLANTS
ZUPNIK·CHEN·YEN·WONG

Charles C. Chen, D.D.S.
Edward A. Zupnik, D.D.S.
C. Alec Yen, D.M.D., M.S.
Choi Yi Wong, D.D.S., M.S.
Andres Jimenez-Wolf D.D.S., M.S.D.
zcywperio.com

MEDICAL HISTORY

Patient Name: _____ Birthdate: _____

Physician: _____ Telephone: _____

1. Are you under medical treatment currently? If yes, please explain:

_____

_____

2. Please list all medication you are taking, including blood thinners, aspirin, cholesterol meds, and any non-presciptions drugs you take on a regular basis:

_____

_____

_____

Are you or have you been on any of the following drugs? Please identify.

Zometa, Aredia, Fosamax, Boniva, Actonel? _____

3. Do you pre-medicate with antibiotics for dental appointments? _____

(Due to heart valve replacement, congenital heart disease, history of infective endocarditis, or joint replacement)

4. Are you allergic to or have you had reactions to:

☐ Local Anesthetic ☐ Latex ☐ Penicillin ☐ Codeine ☐ Tetracycline ☐ Aspirin ☐ Sulfa Drugs

Other _____

DO YOU HAVE, OR HAVE A HISTORY OF?

	YES	NO		YES	NO
High blood pressure	☐	☐	Diabetes	☐	☐
Low blood pressure	☐	☐	Glaucoma	☐	☐
Heart attack	☐	☐	Liver Disease	☐	☐
Heart disease	☐	☐	Hepatitis/jaundice	☐	☐
Heart murmur	☐	☐	Kidney Disease	☐	☐
Mitral valve prolapse	☐	☐	Leukemia	☐	☐
Cardiac Pacemaker	☐	☐	Stomach problems/ulcers	☐	☐
Rheumatic fever	☐	☐	Thyroid problem	☐	☐
Angina	☐	☐	Bleeding disorders	☐	☐
Chest pains	☐	☐	Arthritis	☐	☐
Stroke	☐	☐	Joint Replacement	☐	☐
Respiratory problems	☐	☐	Anemia	☐	☐
Emphysema	☐	☐	Cancer	☐	☐
Tuberculosis	☐	☐	Radiation Therapy	☐	☐
Epilepsy/convulsions	☐	☐	Hay fever/allergies	☐	☐
Fainting/seizures	☐	☐	Asthma	☐	☐
Depression	☐	☐	Aids or HIV Infection	☐	☐
Anxiety	☐	☐	Parkinson's Disease	☐	☐

PLEASE TURN OVER

ZCYW PERIO IMPLANTS
ZUPNIK·CHEN·YEN·WONG

Charles C. Chen, D.D.S.
Edward A. Zupnik, D.D.S.
C. Alec Yen, D.M.D., M.S.
Choi Yi Wong, D.D.S., M.S.
zcywperio.com

MEDICAL HISTORY Continued...

	YES	NO
Do you use tobacco?	☐	☐

FOR WOMEN ONLY

	YES	NO
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

DENTAL HISTORY

	YES	NO
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Do you get fever blisters or ulcers on your lips or in your mouth?	☐	☐
Are you aware of a bad taste or odor in your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
Do you have any loose teeth?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had prolonged bleeding following extractions?	☐	☐
Have you had any adverse dental experience?	☐	☐

I certify by signing below, that the above information is true and correct to the best of my knowledge, and that ZCYW Perio shall not be liable if any misrepresentations are contained here within.

Signature _____ Date _____

Bethesda
Bethesda Medical Building
8218 Wisconsin Ave., Suite 401
Bethesda , Maryland 20814

Tel (301) 656-0331
Fax (301) 656-1325

Olney
Berlin Professional Center
18121 Georgia Ave., Suite 109
Olney, Maryland 20832

Tel (301) 260-1201
Fax (301) 260-1204

Clinton
Southern Building Of Maryland
9131 Piscataway Rd., Suite 720
Clinton, Maryland 20735

Tel (301) 868-7716
Fax (301) 868-2831