GLENN S. LUDWIG, D.M.D., P.C.

Medical History:

Date_____

Name_____ Date of Birth_____ Age _____

Occupation _____ Spouse's Name _____

Home Address _____

_____ Zip Code _____ Home Telephone No. _____

Business Address _____

_____ Zip Code_____ Business Telephone No. _____

Which telephone would be best for messages? _____

How did you first learn of your need for our services? _____

What made you select this office? _____

Your Dentist's Name _____

Address _____

_____ Zip Code _____ Telephone No. _____

Your Physician's Name _____

Address _____

_____ Zip Code _____ Telephone No. _____

Date of last medical examination _____

Name of parent (if minor) _____

Address _____

_____ Zip Code _____ Telephone No. _____

What dental and major medical insurance do you have? _____

_____

Social Security or Insurance I.D. number _____

What is your present problem and what would you like to have handled today? _____

_____

_____

_____

PLEASE COMPLETE REVERSE SIDE

PLEASE WRITE BRIEF ANSWER IF APPROPRIATE	YES	NO	DK*
1. Do you consider yourself to be in good health?	____	____	____
2. Are you under the care of a physician?	____	____	____
3. Have you had any illnesses, operations or been hospitalized?	____	____	____
4. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?	____	____	____
5. Do you have a prosthetic replacement that requires premedication (i.e. knee, hip, wrist, leg)?	____	____	____
6. Have you ever had rheumatic heart disease, rheumatic fever or tuberculosis?	____	____	____
7. Do you have a heart valve replacement or vascular graft?	____	____	____
8. Have you ever been told you have mitral valve prolapse or a heart murmur?	____	____	____
9. Have you ever been told by a doctor that you have high or low blood pressure?	____	____	____
10. Have you ever been told by a doctor that you have heart trouble?	____	____	____
11. Do you have a cardiac pacemaker?	____	____	____
12. Do you have asthma?	____	____	____
13. Have you ever had chronic sinus infections?	____	____	____
14. Have you ever received treatment for any type of endocrine disorder (i.e. thyroid)?	____	____	____
15. Do you have or has anyone in your family had diabetes?	____	____	____
16. Did a doctor ever tell you that you had kidney or bladder trouble?	____	____	____
17. Do you have swollen ankles, arthritis or joint disease?	____	____	____
18. Have you ever tested positive for an autoimmune disease?	____	____	____
19. Has a doctor ever told you that you have stomach ulcers or stomach trouble?	____	____	____
20. Have you ever been treated for jaundice, hepatitis or liver disease?	____	____	____
21. Have you ever had abnormal bleeding following a cut or dental extraction?	____	____	____
22. Have you ever been treated for anemia?	____	____	____
23. Do you bruise easily?	____	____	____
24. Have you ever received chemotherapy or radiation therapy?	____	____	____
25. Has a doctor ever told you that you have osteoporosis?	____	____	____
26. Are you on any special type of diet?	____	____	____
27. Have you ever had severe pains of the face or head?	____	____	____
28. Do you consider yourself nervous?	____	____	____
29. Do you smoke cigarettes, cigars, or a pipe?	____	____	____
30. Are you taking any medications? If so, please list:_____			
31. Do you take a daily aspirin?	____	____	____
32. Have you ever taken cortisone?	____	____	____
33. Are you allergic to or had a reaction to any medication? (aspirin, Ibuprofen, Codeine, Penicillin, Tetracycline, Sulfa, Other: _____)	____	____	____
34. Do you have a latex allergy?	____	____	____
35. (Women) Do you take birth control pills?	____	____	____
36. (Women) Are you pregnant?	____	____	____
37. (Women) Have you ever had hormone replacement therapy?	____	____	____
38. (Women) Do you have any unusual hormonal or gynecological difficulties?	____	____	____
39. Are you taking or have you ever taken bisphosonates?	____	____	____

*DK - Don't Know

_____

Signature

CORONA VIRUS PATIENT CHECKLIST

Please check any of the boxes below that apply. If NONE apply, do not check any box. If you check a box below, you must notify the receptionist immediately.

_____ 1. Do you have a **NEW** cough or runny nose **WITHOUT** fever, chills, or body aches?

_____ 2. Have you recently developed flu like symptoms such as cough **WITH** fever, body aches or chills?

_____3. Have you recently experienced chills, shakes, headache, sore throat or muscle pain?

_____4, Have you experienced a loss of taste or smell?

_____ 5. Have you been exposed to someone who has **tested positive** for Corona virus with or without symptoms? (Exposure means you have been within 6 feet of that person for 2 minutes or more.)

_____6. Do you have any (-) GI symptoms?

_____7. Have you travelled out of the country within the past 4 weeks?

PATIENT NAME (PRINT) _____

PATIENT SIGNATURE: _____

DATE: _____

.