MEDICAL HISTORY Level 1PAGE 1 of 2

REVISED MARCH 24, 2021

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 **Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire, and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

|  |  |  |  |
| --- | --- | --- | --- |
| **Chief Medical Complaints (indicate all previous** [ **P** ] **and current** [ **C** ] **conditions)** |  |  **P** |  **C** |
| 1)  |  |  |
| 2) |  |  |
| 3) |  |  |
| 4) |  |  |
| 5) |  |  |
| **Practitioners (list all medical / alternative practitioners) Treatments (list treatments)**  |
| 1) |  |
| 2) |  |
| 3) |  |
| 4) |  |
|  **Allergies**  |  **YES** |  **NO** |  **DK**  | **SupplementsIndicate Self** [S] **or Doctor** [D] **recommended** |
| ANTIBIOTICS Penicillin / Ciprofloxin / Amoxicillin / Clindamycin / other |  |  |  |
| PAIN KILLERS Codeine / Asprin / other |  |  |  |  1) |  |
| OTHER DRUGS Local Anesthetics / Barbiturates / other |  |  |  |  2) |  |
| FOODS Shellfish / Iodine / Nuts / Grains / Dairy |  |  |  |  3) |  |
| TOXICITY Metals / Plastics / Ceramics / Latex |  |  |  |  4) |  |
| MISCELLANEOUS Hayfever / Pollen / Animals |  |  |  |  5)  |  |
| ENVIRONMENTAL ILLNESS EMFs / Chemicals |  |  |  |  6) |  |
| **Lifestyle** |  |  7) |  |
| **HOURS WORKED** |  8) |  |
| PRIMARY Occupation |  / week |  9) |  |
| SECONDARY Occupation |  / week | 10) |  |
| SLEEP QUALITY 🞏 Good 🞏 Fair 🞏 Poor SLEEP QUANTITY Number of hours/daily =  | **MedicationsList over-the-counter (OTC) meds taken** |
| STRESS LEVELS 🞏 High 🞏 Moderate 🞏 Low Is it manageable? 🞏 YES 🞏 NO 🞏 Somewhat |
| DENTAL STRESS List major concerns > | 1) |
| Anxiety before appointments 🞏 YES 🞏 NO 🞏 Somewhat  | Are you grinding your teeth? 🞏 YES 🞏 NO  | 2) |
| EXERCISE 🞏 Gym 🞏 Sports 🞏 Yoga / Pilates / Tai Chi 🞏 Other >  | 3) |
| RELAXATION 🞏 Meditation 🞏 Nature 🞏 Other > | 4) |

**Pre-Clearance**

**Do you have any of the following diseases or conditions?** (check box for **DK** if you “Don’t Know” the answer)

Active Tuberculosis (TB) Persistent or Bloody Cough Antibiotic Recent CoVid-19 Exposure

(previous or recent exposure) (greater than 3-week duration) Pre-Medication (high-risk patients, severe requiring hospitalization, high fear factor)

 🞏 YES 🞏 NO 🞏 DK 🞏 YES 🞏 NO 🞏 DK 🞏 YES 🞏 NO 🞏 DK 🞏 YES 🞏 NO 🞏 DK

 🞏 Hip/knee/elbow replacement (recent) 🞏 Heart valve replacement 🞏 Previous infective endocarditis 🞏 Congenital heart disease

 **For all “YES” or “DON’T KNOW” answers, call the office at (908) 464-9144 several days prior to arriving**

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*(continued)*

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|  |  |
| --- | --- |
|  **Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Diet and Nutrition** |  |
| 1) **How would you characterize your basic diet?**🞏 Carnivore (All meat, few or no vegetables or fruit)🞏 Omnivore (meats, vegetables and fruit)🞏 Vegetarian (vegetables, dairy, eggs)🞏 Vegan (vegetables only) |  | 2) **Are you on a medical diet?** 🞏 YES 🞏 NO 🞏 SOMEWHAT 🞏 Cardiovascular🞏 Diabetic🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|
| 3) **Do you restrict certain foods due to potential allergies and intolerance?** 🞏 YES 🞏 NO 🞏 SOMEWHAT 🞏 Grains🞏 Dairy 🞏 Nuts 🞏 Gluten 🞏 Shellfish 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4) **Do you have any completely raw meals in a day?** 🞏 YES 🞏 NO  |
| **Social History (indicate all previous** [ **P** ] **and current** [ **C** ] **conditions)** |
| **SMOKING** 🞏 YES 🞏 NONicotine |  **P** |  **C** |  **SUGAR**Teaspoons added to drinks \_\_\_\_\_\_\_ / day | **P** | **C** |
|  |  |  |  |
| Cannabis (medical/recreational) |  |  | Liquid sugars (soda, ice cream) ) \_\_\_\_\_\_\_ amount / week |  |  |
| Oral Nicotine / Vaping |  |  | Mild sugars (health food snacks) \_\_\_\_\_\_\_ amount / week  |  |  |
| Other drugs (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Hard (addictive) sugars (soda, ice cream) *Are you addicted to sugar?* 🞏 YES 🞏 NO 🞏 DON’T KNOW  |  |  |
| *Are you interested in stopping?* 🞏 YES 🞏 NO | Store-bought snacks that include (or may include if 🞏 YES 🞏 NOyou don’t read labels) HFCS (high fructose corn syrup),agave, fructose, sucrose, corn syrup? |  |  |
| **ALCOHOL** 🞏 YES 🞏 NOWine / Beer / Cocktails \_\_\_\_drinks / week |  |  |
| **CAFFEINE** 🞏 YES 🞏 NO | Drinksper day | **P** | **C** | Artificial sweeteners (exotoxins) such as aspartame, 🞏 YES 🞏 NOsaccharin, stevia (non-herbal forms)?  |  |  |
| Espresso |  |  |  |
| Coffee |  |  |  | *Are you interested in stopping sugar addiction?* 🞏 YES 🞏 NO |  |  |
| Black Tea |  |  |  | **CHOCOLATE**Chocolate consumption \_\_\_\_\_\_\_ amount / week |  **P** |  **C** |
| Energy Drinks  |  |  |  |  |  |

**✪ STOP HERE and SIGN IF YOU HAVE NO MEDICAL CONDITIONS, DISEASES, SYMPTOMS or TREATMENTS ✪
FOR THOSE WHO DO, COMPLETE MEDICAL HISTORY Level 2**

NOTE **Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history, and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions
that I may have made in the completion of this form.

SIGNATURE of PATIENT / LEGAL GUARDIAN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE of DENTIST

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_