

GREENWICH DENTAL GROUP

DAVID A. ZADIK DDS AND ASSOCIATES

COSMETIC, GENERAL AND IMPLANT DENTISTRY

Health Information

Please list any medications taken, and indicate all allergies you have:

Have you ever had any of the following? Please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Allergies/Hayfever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis/Rheumatism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> X-Ray Treatments | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> IV Bisphosphonate | <input type="checkbox"/> Zometa/Aredia Treatment |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Murmur/Mitral Valve Prolapse/Heart Disease |
| <input type="checkbox"/> Hepatitis (A)(B)(C) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Joint Replacement/pins Date _____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Mental/Nervous Disorders | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Pregnancy Due Date _____ | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems/Ulcers |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Smoker QTY _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Venereal Disease |