Facility:

Patient Name _____ **Birthdate** _____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

Y N Has there been any change in your general health in the past year?
If so please describe: _____

Date of last physical exam _____

Y N Are you now under a physician's care for a particular problem?
If so please describe: _____

Y N Have you had any serious illness, operations, or hospitalizations?
If so please describe: _____

Y N Have you had any adverse effects from dental treatment or anesthesia?
If so please describe: _____

Do you have or have you ever had:

Y N Infective Endocarditis

Y N Born with Heart Defects

Y N Artificial heart valve

Y N Stents placed in arteries
If so when? _____

Y N Do you require antibiotics prior to dental treatment?
*What type/dosage?*_____

Y N Cardiovascular Disease (please circle)
Heart trouble, Heart Attack, Heart Murmur,
Coronary Artery Disease , Angina, Stroke, TIA
Palpitations, Heart Surgery, Pace Maker, Chest Pain
Do you carry Nitroglycerin with you? Y N
*How often do you use it?*_____

Y N High/Low Blood Pressure

Y N Lung Disease / Asthma (please circle)
Emphysema, Chronic Cough, Bronchitis, Pneumonia,
Tuberculosis, Shortness of Breath,
Severe coughing, COPD
Do you use an inhaler? Y N

Y N Bleeding Disorder (please circle)
Blood thinners, Tendency to bruise, Anemia,
Bleeding tendency, Blood transfusion?

Y N Artificial Joints placed anywhere in your body
Hip, Knee, Shoulder
Date (s) of surgery_____

Y N Radiation or chemo treatment for cancer
Type /Year_____

Y N Liver Disease (please circle)
Jaundice, Hepatitis A B C

Y N Diabetes (please circle) Type I or Type II
Most recent A1C_____ Blood Sugar Level_____

Y N Kidney Disease

Y N Seizures, Convulsions, Epilepsy

Y N Fainting, Dizziness

Y N Psychiatric treatment

Y N Nervous/Anxiety disorder

Y N Hypoglycemia

Y N Acid Reflux or GERD or Heart Burn

Y N Thyroid Disease (please circle)
Goiter, Hypothyroid, Hyperthyroid

Y N Arthritis

Y N Stomach Ulcers/ Colitis

Y N Glaucoma

Y N Frequent or recurring mouth sores

Y N Sleep apnea
Do you use a CPAP machine? Y N
Day time sleepiness? Y N

Y N Sinus or nasal problems

Y N Have you had a recent injury to your head/jaw?

Y N Have you been treated for a jaw joint problem?

Y N Clicking / popping of jaw joint, pain near ear,
difficulty opening your mouth?

Y N Do you grind or clench your teeth?

Y N Do you have frequest headaches?

Y N Sexually transmitted diseases, HIV/AIDS, HPV, _____

Y N Any disease, drugs or transplant operation that has
suppressed your immune system?

Y N Alcohol or Drug addiction

Please list any medication you are currently taking, including any aspirin, vitamins or herbal/homeopathic supplements: _____

_____

_____

_____

Are you allergic to or have you had a bad reaction to any of the following? Y N
(please circle all that apply)

Local anesthetic (novocaine, xylocaine, etc) Penicillin, Amoxicillin, Sulfa, Cephalosporins, Tetracycline, Erythromycin, or other antibiotics Barbiturates, Valium, or other sedatives, etc Food Allergies (i.e.: eggs,milk,shellfish etc...) _____ _____ _____	Aspirin, Acetaminophen, or Ibuporfen Codeine, Demerol, Percodan or other pain killers _____ Latex Other allergic reactions: _____ _____ _____ _____

Y N History of Bisphosphonate treatment
(Fosamax, Boniva, Actonel, Atelvia, Reclast, Alendronate, Ibandronate, Risedronate, Zoledronic)

Y N Do you smoke or chew tobacco?
If so, how much per day & for how many years _____

Y N Do you have any other disease, condition or problem not listed above that you think the doctor should know about?
If so what? _____

Y N Do you wish to speak with the doctor privately about anything?

Y N Are you pregnant, or is there a possibility that you may be pregnant?

Y N Are you nervous about having dental treatment?

Y N Have you ever had a bad dental experience?

Y N Do your gums bleed?

Y N Have you had periodontal disease or periodontal surgery?

Y N Are your teeth sensitive to
cold / heat / pressure / sweet etc?

Previous dentist's name _____

Immediate dental concern _____

_____

If you could change anything about your smile what would it be?

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover

Patient Name (printed) _____

Patient (parent/guardian) signature _____

Date _____