

NAME _____ BIRTHDATE _____ AGE _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

- | | Y | N |
|---|---|---|
| 1. Are you in good health now? | | |
| 2. Are you under the care of a physician? | | |
| If so, what is the condition being treated? _____ | | |
| 3. Have you ever been hospitalized or had a serious illness? | | |
| If yes, explain _____ | | |
| 4. Have you ever had excessive bleeding following an extraction. Do cuts take longer to heal? | | |
| 5. (Women) Are you pregnant? If so, give due date _____ | | |
| 6. Do you use tobacco in any form? If yes, how much? _____ | | |
| 7. Do you use alcoholic beverages? If yes, how much? _____ | | |
| 8. Do you have or have you ever had any of the following? | | |

GENERAL

Allergic reactions

| Y | N |
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SKIN

Eczema/Psoriasis

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Changes in skin color/moles

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NERVOUS SYSTEM

Stroke

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Severe headaches

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Convulsions/epilepsy

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Numbness/tingling

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Dizziness/fainting

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Psychiatric treatment

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RESPIRATORY

Tuberculosis

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Emphysema

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Asthma/hay fever

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Persistent cough

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ENDOCRINE

Diabetes

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Family history of Diabetes

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Thyroid condition/goiter

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OTHER

Radiation therapy

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Cancer

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Chemotherapy

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HIV+/AIDS

HEART/BLOOD VESSELS

Rheumatic fever

| Y | N |
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Heart murmur

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Chest pain/discomfort

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Heart attack/trouble

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Shortness of breath

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Swelling of ankles

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High blood pressure

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Congenital heart disease

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Mitral valve prolapse

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Artificial heart valve

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Pacemaker

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Heart surgery

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BONE/MUSCLES

Artificial joints/limbs

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Arthritis/rheumatism

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DIGESTIVE SYSTEM

Hepatitis

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Ulcers

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Jaundice

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BLOOD

Anemia

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Bruise easily

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Blood transfusion

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URINARY

Kidney disease

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Venereal disease

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| 9. Do you need to premedicate prior to your dental appointments? | | |
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10. Are you **ALLERGIC** or have you ever experienced any reaction to the following?

| | Y | N | | Y | N |
|---------------------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| Local anesthetics (e.g. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin or codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates/sedatives/sleeping pills | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin/other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Other allergies _____ | | |

11. Are you **CURRENTLY TAKING** any of the following?

| | Y | N | | Y | N |
|------------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
| Antibiotics/sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> | Heart medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Fosamax/Boniva | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone/steroids | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood thinners | <input type="checkbox"/> | <input type="checkbox"/> | Nitroglycerin | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin/other Diabetes drugs | <input type="checkbox"/> | <input type="checkbox"/> | Antihistamines/allergy drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure medication | <input type="checkbox"/> | <input type="checkbox"/> | Cold remedies | <input type="checkbox"/> | <input type="checkbox"/> |
| Recreational drugs | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid medication | <input type="checkbox"/> | <input type="checkbox"/> | Birth Control | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | | | |

If yes to any of the above currently taken medication, list below:

| <u>Medication</u> | <u>Dosage</u> |
|-------------------|---------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

12. If you ever had any Bisphosphonate therapy for Osteoporosis, when was it and what was prescribed?

13. Physicians Name _____ Phone Number _____

14. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?

If so, when? _____

15. Does dental treatment make you nervous? No ___ Slightly ___ Moderately ___ Extremely ___

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or a change in my medications, I will inform your office at the next appointment.

Signature of Patient or Guardian _____ Date _____