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	Y	N
Allergic reactions		
SKIN		
Eczema/Psoriasis		
Changes in skin color/moles		
NERVOUS SYSTEM		
Stroke		
Severe headaches		
Convulsions/epilepsy		
Numbness/tingling		
Dizziness/fainting		
Psychiatric treatment		
RESPIRATORY		
Tuberculosis		
Emphysema		
Asthma/hay fever		
Persistent cough		
ENDOCRINE		
Diabetes		
Family history of Diabetes		
Thyroid condition/goiter		
OTHER		
Radiation therapy		
Cancer		
Chemotherapy		
HIV+/AIDS		

HEART/BLOOD VESSELS	Y	N
Rheumatic fever		
Heart murmur		
Chest pain/discomfort		
Heart attack/trouble		
Shortness of breath		
Swelling of ankles		
High blood pressure		
Congenital heart disease		
Mitral valve prolapse		
Artificial heart valve		
Pacemaker		
Heart surgery		
BONE/MUSCLES		
Artificial joints/limbs		
Arthritis/rheumatism		
DIGESTIVE SYSTEM		
Hepatitis		
Ulcers		
Jaundice		
BLOOD		
Anemia		
Bruise easily		
Blood transfusion		
URINARY		
Kidney disease		
Venereal disease		

9. Do you need to **premedicate** prior to your dental appointments? | | |

10. **Are you <u>ALLERGIC</u> or have you ever experienced any reaction to the following?**

	Y	N		Y	N
Local anesthetics (e.g. novocaine)			Aspirin or codeine		
Barbiturates/sedatives/sleeping pills			Sulfa drugs		
Penicillin/other antibiotics			Other allergies _____		

11. **Are you <u>CURRENTLY TAKING</u> any of the following?**

	Y	N		Y	N
Antibiotics/sulfa drugs			Heart medication		
Fosamax/Boniva			Cortisone/steroids		
Blood thinners			Nitroglycerin		
Insulin/other Diabetes drugs			Antihistamines/allergy drugs		
Blood pressure medication			Cold remedies		
Recreational drugs			Aspirin		
Thyroid medication			Birth Control		
Other					

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 _____