



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

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

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

*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 Cardiovascular Disease (please circle)

Heart trouble, Heart Attack, Heart Murmur

Coronary Artery Disease , Angina, Stroke, TIA

Palpitations, Heart Surgery, Pace Maker

*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,

Chest pain, Severe coughing

*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 Thyroid Disease (please circle)

Goiter, hypothyroid, hyperthyroid

Y N Arthritis

Y N Stomach Ulcers/ Colitis

Y N Acid Reflux, GERD, Heart Burn

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 frequent headaches?

Y N Sexually transmitted diseases, HIV/AIDS

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:**

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**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)	Aspirin, Acetaminophen, or Ibuprofen
Penicillin, Amoxicillin, Sulfa, Cephalosporin, Tetracycline or other antibiotics	Codeine, Demerol, Percodan, or other pain killers _____
Barbiturates, Valium, or other sedatives, etc.	Latex
Food Allergies (i.e.: eggs, milk, shellfish etc. . . ) _____	Other allergic reactions: _____ _____

Y N History of Biophosphonate treatment

(Fosamax, Boniva, Actonel, Atelvia, Reclast, Alendronate, Ibandronate, Risedronate, Zoledronic)

Y N Do you smoke or chew tobacco?

*If so, how much per day and 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 \_\_\_\_\_  
\_\_\_\_\_

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.

**Patient Name (printed)**

**Patient (parent/guardian) signature**

**Date**