

Patient Name: _____ Birth Date: _____ Date Created: _____

Disclaimer

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering all questions.

- Are you under a physician's care now? Yes No If yes _____
- Have you ever been hospitalized or had a major operation? Yes No If yes _____
- Have you ever had a serious head or neck injury? Yes No If yes _____
- Are you taking any medications, pills, or drugs? Yes No If yes _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____
- Are you taking blood thinners? Yes No
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____
- Are you on a special diet? Yes No
- Do you use tobacco/vape? Yes No
- Are you currently being rehabilitated for drug or alcohol abuse? Yes No If yes _____
- Do you use alcohol? If yes, what is the frequency? Yes No
- Have you been or are you being treated by a pain management specialist? Yes No

Do you have, or have you had, any of the following?

- | | | | |
|--|--|---|--|
| Aids/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Anemia <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Asthma <input type="radio"/> Yes <input type="radio"/> No | Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Acid Reflux <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Autism <input type="radio"/> Yes <input type="radio"/> No | Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Breathing Problems <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Congenital Heart Disease <input type="radio"/> Yes <input type="radio"/> No |
| Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Cancer <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | C-Pap Machine <input type="radio"/> Yes <input type="radio"/> No | Convulsions <input type="radio"/> Yes <input type="radio"/> No | Dementia <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction/Use <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Epilepsy/Seizures <input type="radio"/> Yes <input type="radio"/> No |
| Emphysema <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No |
| Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Gerd <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No |
| Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No |
| High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No |
| Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Heart Disease <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No |
| Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No |
| Leukemia <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No |
| Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Oral Herpes/Cold Sores <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Pain Management <input type="radio"/> Yes <input type="radio"/> No |
| Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Sleep Study <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Spira Bifida <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Tonsillitis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Venereal Disease <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No | | |

Have you ever had any serious illness not listed above? Yes No If yes _____

TURN OVER TO COMPLETE ----->

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Sulfa Drugs

Local Anesthetics

Other?

If yes

Dental History

Chief Concern

Date of last dental visit.

Do you have any of the following? If yes, please list the date received to the best of your knowledge.

Crowns

Yes No

Implants

Yes No

Partial/Denture/Flipper

Yes No

Have you undergone orthodontic treatment? If so, when?

Do you wear retainers?

Yes No

Do you have a metal retainer attached to

Yes No

Do you chew: ice, nails, pens, other.

Yes No

Do you eat candy, snacks or both? What frequency?

Yes No

Circle any of the following you drink: tea, sweet tea, coffee, sodas, sports drinks, energy drinks, juice, water, milk

Yes No

Are you currently taking any pain medication for your dental pain?

Yes No

Have you seen another dentist/doctor for treatment of your dental pain?

Yes No

Are you being treated for your dental pain by another dentist/doctor?

Yes No

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____