Name ______________________________ Date ____________________

Date of last health care exam: ________________ What was this exam for? ______________________

Have you been hospitalized or had surgery? (Please circle) No Yes

If yes, reason: ____

Are you currently receiving care? No Yes If yes, nature of care: ______________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____
4. ____

Have you ever had an allergic reactions to Novocain, local or general anesthetics? If yes please explain:

____

Have you had trouble from previous dental care? If yes please explain what happen

____

Reason for today's visit? ______________________ Date of Last dental exam? ____________________

Former Dentist? ______________________ Date of Last dental x-rays? ____________________

Please indicate if you have or had the following:

Bad Breath	No	Yes	Gums swollen, tender, or bleeding	No	Yes
Blisters on the lips or in the mouth	No	Yes	Head, neck, or jaw pain or aches	No	Yes
Burning sensation on the tongue	No	Yes	Lip or cheek biting	No	Yes
Chew on one side of your mouth	No	Yes	Loose teeth or broken fillings	No	Yes
Cigarette, pipe, cigar smoking	No	Yes	Mouth breathing	No	Yes
Smokeless – Smoking	No	Yes	Orthodontic treatment	No	Yes
Dry mouth	No	Yes	Nitrous Oxide – Laughing Gas	No	Yes
Food collection between teeth	No	Yes	Periodontal treatment	No	Yes
Clench teeth	No	Yes	Sensitivity to pressure or irritants	No	Yes
Grind teeth	No	Yes	How often do you floss?		
Growths or sore spots in mouth	No	Yes	How often do you brush your teeth?		

For the following questions circle yes or no.

Blood Disorders?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma, COPD or other Lung Diseases	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychiatric Therapy	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Renal Dialysis	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery, Angina	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes		Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes		Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
St. John's Wort or Kava-Kava?	No	Yes		Serzone® (nefazodone)	No	Yes
Dilantin® or Tegretol®	No	Yes		Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
Barbiturates (any)	No	Yes		Biaxin® (clarithromycin)	No	Yes
				Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin? When did the treatment end?	No	Yes
				Have you ever taken any prescription drugs such as fen-phen for weight loss?	No	Yes
				Do you consume grapefruit juice, grapefruits or grapefruit extract?	No	Yes

Please list any medications you are currently taking and dosages:

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________
7. ______________________ 8. ______________________

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
Have you ever received a diagnosis of "high blood pressure" or "low blood pressure"?
What is your normal blood pressure? S /D Today: __________/_____

Are you allergic or have you had a reaction to:

a. Local anesthetics or epinephrine………………………………………... No Yes
b. Penicillin or other antibiotics …………………………………………… No Yes
c. Aspirin, Ibuprofen or Tylenol® …..……………………………………… No Yes
d. Codeine, Valium®, Hydrocodone, Oxycodone or other sedatives……… No Yes
e. Latex or Metals
f. Other (please specify)______________________________

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*			

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

____
____
____
____
____

Significant findings from questionnaire or oral interview:

____
____
____
____
____

Dental management considerations:

____
____
____
____
____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_________________________	_________________________	_______________
Patient (Print Name)	*Patient Signature*	*Date*
_________________________	_________________________	_______________
Doctor (Print Name)	*Doctor Signature*	*Date*