

Although dental personnel treat in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you in good health? Yes No

Has there been any change in your general health within the past year? Yes No

My last physical examination was on.....

Are you now under the care of a physician? Yes No

If Yes, what is the condition being treated?.....

The name and address of my physician is

.....

Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No

If so, what was the illness or problem?

Are you taking any medicine(s)? Please include prescription medications, vitamins, herbal supplements and over-the-counter medications. Yes No

If so, what medicine(s) are you taking?

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Do you take aspirin daily? Yes No

Do you have a medical condition that requires you to take antibiotics before dental appointments? Yes No

Do you have or have you had any of the following diseases or problems?

Do you have artificial heart valves, a history of ineffective endocarditis, or congestive heart failure? Yes No

Cardiovascular disease (heart trouble, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) Yes No

Surgery to replace joints or surgery that resulted in pins or plates being placed in your body Yes No

Do you have chest pain upon exertion? Yes No

Are you ever short of breath after mild exercise or when lying down? Yes No

Do your ankles swell? Yes No

Were you born with heart defects? Yes No

Do you have a cardiac pacemaker? Yes No

Allergies Yes No

Sinus trouble Yes No

Asthma or hay fever Yes No

Fainting spells or seizures Yes No

Persistent diarrhea or recent weight loss Yes No

Diabetes Yes No

Hepatitis, jaundice or liver disease Yes No

AIDS or HIV infection Yes No

Thyroid problems Yes No

Respiratory problems, emphysema, bronchitis Yes No

Arthritis or painful swollen joints Yes No

Stomach ulcer, hyperacidity, GERD or reflux Yes No

Kidney trouble Yes No

Tuberculosis Yes No

Persistent cough or cough that produces blood Yes No

Persistent swollen glands in neck Yes No

Low blood pressure Yes No

Sexually transmitted disease Yes No

Epilepsy or other neurological disease Yes No

Depression and/or anxiety Yes No

Cancer—Chemotherapy and/or radiation of the head and neck Yes No

Problems of the immune system Yes No

(Page 2 of 2)

- Have you had abnormal bleeding? Yes No
- Have you ever required a blood transfusion? Yes No
- Do you have any blood disorder such as anemia? Yes No
- Have you ever had any treatment for a tumor or growth? Yes No

Are you allergic or have you had a reaction to:

- Local anesthetics Yes No
- Penicillin or other antibiotics Yes No
- Sulfa drugs Yes No
- Barbiturates, sedatives, or sleeping pills Yes No
- Aspirin Yes No
- Iodine Yes No
- Codeine or other narcotics Yes No
- Latex Yes No
- Metals Yes No
- Acrylic Yes No

Foods: Yes No

Specify:
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Other Yes No

Specify:
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.....

Have you had any serious trouble associated with any previous dental treatment? Yes No

If so, explain.....
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.....

Do you have popping, clicking, and/or pain of your jaw joint? Yes No

Do you have any disease, condition, or problem not listed above
that you think I should know about? Yes No

If so, explain.....
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Are you wearing contact lenses? Yes No

Are you wearing removable dental appliances? Yes No

Do you use tobacco products? Yes No

If so, what type, and how frequently?.....

Do you drink alcoholic beverages? Yes No

If so, what type, and how frequently?.....

Women:

Are you pregnant? Yes No

Do you have any problems associated with your menstrual period? Yes No

Are you nursing? Yes No

Are you taking birth control pills? Yes No

Chief Dental Complaint:

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I certify that I have read and understand the above questions. I have answered them as truthfully and thoroughly as possible. I will not hold my dentist, or any other member of her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient _____
Date

Signature of Dentist _____
Date