

Patient Name: _____ Birth Date: _____

I. PLEASE CIRCLE APPROPRIATE ANSWER FOR EACH:

DO YOU HAVE OR HAVE YOU HAD:

- | | | |
|--|------------------------------------|--------------------------------------|
| Yes No Heart Disease | Yes No Difficulty swallowing | Yes No Arthritis/Rheumatism |
| Yes No Heart Attack | Yes No Diarrhea/Constipation | Yes No Artificial Joint/ Replacement |
| Yes No High Blood Pressure | Yes No Vomiting/Nausea | Yes No AIDS/HIV |
| Yes No Chest Pain (Angina) | Yes No Bloody Stool/Urine | Yes No Herpes Simplex |
| Yes No Congenital Heart Defect/
disease | Yes No Stomach Problems/Ulcers | Yes No Skin Disease |
| Yes No Infection of the Heart or Blood | Yes No Thyroid/Adrenal Dysfunction | Yes No Eye Disease |
| Yes No Prosthetic Heart Valve | Yes No Headaches/Dizziness | Yes No Cancer |
| Yes No Pacemaker/Implanted Device | Yes No Fainting | Yes No Radiation Treatments |
| Yes No Stroke | Yes No Seizures | Yes No Chemotherapy |
| Yes No Bleeding Problems | Yes No Increase Thirst/Urination | Yes No Blood Transfusion |
| Yes No Blood disease/disorders | Yes No Diabetes | Yes No Psychiatric care |
| Yes No Anemia | Yes No Kidney Disease | Yes No Tobacco (any form) |
| Yes No Sinus Problems | Yes No Hepatitis/Liver Disease | Yes No Alcoholism |
| Yes No Asthma | Yes No Dry Mouth | Yes No Recreational Drugs |
| Yes No TB (Tuberculosis) | Yes No Joint Pain/Stiffness | Yes No Are you Pregnant/ Nursing |
| Yes No COPD/Emphysema | Yes No Osteoporosis | Yes No Taking Birth Control |
| | | Yes No Diagnosis Sleep Apnea |

PLEASE LIST ANY OTHER DISEASES/MEDICAL CONCERNS: _____

II. ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY OF THE FOLLOWING?

Penicillin Codeine Aspirin Nitrous Oxide Local Anesthetic Latex Motrin/Ibuprofen

PLEASE LIST ALL OTHER ALLERGIES: _____

III. PLEASE PROVIDE A LIST OF ALL MEDICATIONS YOU ARE TAKING AND WHAT THEY ARE FOR:

IV. PLEASE LIST ALL HOSPITALIZATIONS/SURGERIES/PROCEDURES IN THE PAST 10 YEARS:

To the best of my knowledge, I have answered all questions completely and accurately. I will inform my dentist of any changes in my health and/or medications at each visit.



Patient Signature: _____ Date: _____