

# Patient Dental & Medical Health History Information

**To our patients:** Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

| PATIENT INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |               |                                                                                                                                                       |              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--|
| Last Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | First Name:   |                                                                                                                                                       | Middle Name: |  |
| Home Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | Cell Phone:   |                                                                                                                                                       | Work Phone:  |  |
| Email Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |               |                                                                                                                                                       |              |  |
| Mailing Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | City:         |                                                                                                                                                       | State: Zip:  |  |
| Date of Birth: / /                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Gender:       |                                                                                                                                                       |              |  |
| Occupation:                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |               |                                                                                                                                                       |              |  |
| Emergency Contact: Name:                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | Relationship: |                                                                                                                                                       | Phone:       |  |
| If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____<br>If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing. |  |               |                                                                                                                                                       |              |  |
| DENTAL HISTORY & SYMPTOMS                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |               |                                                                                                                                                       |              |  |
| What is the reason for your visit today?                                                                                                                                                                                                                                                                                                                                                                                                                               |  |               |                                                                                                                                                       |              |  |
| Are you currently experiencing any dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?                                                                                                                                                                                                                                                                                                                                  |  |               |                                                                                                                                                       |              |  |
| When was your last dental exam? / / What was done at that appointment?                                                                                                                                                                                                                                                                                                                                                                                                 |  |               |                                                                                                                                                       |              |  |
| When was the last time you had dental x-rays taken?                                                                                                                                                                                                                                                                                                                                                                                                                    |  |               |                                                                                                                                                       |              |  |
| Please mark an "X" in the box ONLY if this applies to you.                                                                                                                                                                                                                                                                                                                                                                                                             |  |               |                                                                                                                                                       |              |  |
| Is it hard to open your mouth? <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                |  |               | Have you ever had a serious injury to your head or mouth? <input type="checkbox"/>                                                                    |              |  |
| Does it hurt to chew, bite or swallow? <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                        |  |               | If yes, please describe what happened and when it happened: _____                                                                                     |              |  |
| Do your gums bleed when you brush or floss your teeth? <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                        |  |               | Have you ever had problems with dental treatment in the past? <input type="checkbox"/>                                                                |              |  |
| Have you ever had periodontal (gum) treatments like scaling and root planing? <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                 |  |               | If yes, please describe what happened: _____                                                                                                          |              |  |
| Do you have, or have you ever had, any sores or growths in your mouth? <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                        |  |               | Have you ever had a reaction to, or problem with, dental anesthesia? <input type="checkbox"/>                                                         |              |  |
| Do you clench or grind your teeth? <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                            |  |               | If yes, please describe what happened: _____                                                                                                          |              |  |
| Does your jaw click, pop or hurt? <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                             |  |               | Are you unhappy with your smile? <input type="checkbox"/>                                                                                             |              |  |
| Do you have earaches or neck pains? <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                           |  |               | If yes, why? Please mark all that apply:                                                                                                              |              |  |
| Does dental treatment make you nervous? <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                       |  |               | <input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth |              |  |
| Have you ever experienced any of these sleep-related breathing disorders? <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                     |  |               | <input type="checkbox"/> Other. Please describe: _____                                                                                                |              |  |
| <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep                                                                                                                                                                                                                                                                                                                                      |  |               |                                                                                                                                                       |              |  |
| MEDICATIONS & OTHER PRODUCTS/SUBSTANCES                                                                                                                                                                                                                                                                                                                                                                                                                                |  |               |                                                                                                                                                       |              |  |
| Please use an "X" to mark your answers to the following questions. Yes No ?                                                                                                                                                                                                                                                                                                                                                                                            |  |               |                                                                                                                                                       |              |  |
| Are you taking any <b>blood thinners</b> (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                            |  |               |                                                                                                                                                       |              |  |
| If yes, what medication are you taking? _____                                                                                                                                                                                                                                                                                                                                                                                                                          |  |               |                                                                                                                                                       |              |  |
| Are you taking any medication to treat <b>osteoporosis</b> or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                              |  |               |                                                                                                                                                       |              |  |
| Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).                                                                                                                                                                                                                                                                                                         |  |               |                                                                                                                                                       |              |  |
| If yes, what medication are you taking? _____                                                                                                                                                                                                                                                                                                                                                                                                                          |  |               |                                                                                                                                                       |              |  |
| Are you taking, or scheduled to take, an <b>IV medication</b> to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                            |  |               |                                                                                                                                                       |              |  |
| Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).                                                                                                                                                                                                                                                                                                                                                             |  |               |                                                                                                                                                       |              |  |
| If yes, what medication are you taking? _____ How many years have you been taking it? _____                                                                                                                                                                                                                                                                                                                                                                            |  |               |                                                                                                                                                       |              |  |
| Are you taking <b>hormonal replacements</b> ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                               |  |               |                                                                                                                                                       |              |  |
| Do you use any form of <b>tobacco or nicotine products</b> (cigarettes, cigars, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                        |  |               |                                                                                                                                                       |              |  |
| Do you use <b>vaping products</b> ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                         |  |               |                                                                                                                                                       |              |  |
| How many <b>alcoholic beverages</b> do you have per week? _____                                                                                                                                                                                                                                                                                                                                                                                                        |  |               |                                                                                                                                                       |              |  |
| Do you use <b>controlled substances</b> (drugs), including marijuana, for either medicinal or recreational reasons? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                         |  |               |                                                                                                                                                       |              |  |
| If yes, what substances? _____ If yes, how often is your use? <input type="checkbox"/> Daily <input type="checkbox"/> Several times per week <input type="checkbox"/> Weekly <input type="checkbox"/> Occasionally                                                                                                                                                                                                                                                     |  |               |                                                                                                                                                       |              |  |
| Was the substance prescribed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason(s)? _____                                                                                                                                                                                                                                                                                                                                   |  |               |                                                                                                                                                       |              |  |
| Do you take any other <b>prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements</b> ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                        |  |               |                                                                                                                                                       |              |  |
| If yes, please list them here and include information about how much and how often you use each one. _____                                                                                                                                                                                                                                                                                                                                                             |  |               |                                                                                                                                                       |              |  |
| <b>WOMEN ONLY:</b> Are you:                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |               |                                                                                                                                                       |              |  |
| Taking <b>birth control pills</b> ? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                         |  |               |                                                                                                                                                       |              |  |
| <b>Pregnant?</b> If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |  |               |                                                                                                                                                       |              |  |
| <b>Nursing?</b> If yes, number of weeks: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |  |               |                                                                                                                                                       |              |  |

|                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ALLERGIES Please use an "X" to mark your answers to the following questions.                                                                                                                                                                                                            |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Are you allergic to or have you had an allergic reaction to:                                                                                                                                                                                                                            |  | Yes No ?                                                                                                                               | Yes No ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Aspirin .....                                                                                                                                                                                                                                                                           |  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                             | Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Other ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>Please describe any "Yes" answers and include information about your experience.<br>_____ |
| Barbiturates, sedatives or sleeping pills .....                                                                                                                                                                                                                                         |  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Codeine or other narcotics .....                                                                                                                                                                                                                                                        |  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Hay fever/seasonal allergies .....                                                                                                                                                                                                                                                      |  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Iodine .....                                                                                                                                                                                                                                                                            |  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Latex (rubber) .....                                                                                                                                                                                                                                                                    |  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Local anesthetics.....                                                                                                                                                                                                                                                                  |  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Metals .....                                                                                                                                                                                                                                                                            |  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Penicillin or other antibiotics.....                                                                                                                                                                                                                                                    |  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| MEDICAL & SURGICAL HISTORY                                                                                                                                                                                                                                                              |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Date of last physical exam:        /        /                                                                                                                                                                                                                                           |  | What is your normal blood pressure (systolic, diastolic)?                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Doctor's Name:                                                                                                                                                                                                                                                                          |  | Phone:                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Please use an "X" to mark your answers to the following questions.                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Are you in good physical health? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                       |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Are you currently being seen or treated by a physician? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Has a physician or previous dentist recommended that you take <b>antibiotics</b> before having dental work done? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                       |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Have you had a <b>serious illness, operation or been hospitalized</b> in the past 5 years? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                             |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Have you had any type (either total or partial) of <b>joint replacement</b> surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                          |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Have you had a <b>heart valve replacement or heart surgery</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                       |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Have you had an <b>organ or bone marrow/stem cell transplant</b> ? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                     |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Have you traveled internationally within the last 30 days ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                              |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Have you had a fever (100.4°F or above) in the last 72 hours? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                          |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| If you answered yes to any of the above, please explain: _____                                                                                                                                                                                                                          |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.                                                                                                                                                                                             |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Do you have, or have you been diagnosed with, any of the following conditions?                                                                                                                                                                                                          |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Yes No ?                                                                                                                                                                                                                                                                                |  | Yes No ?                                                                                                                               | Yes No ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Heart (Cardiac) Health</b>                                                                                                                                                                                                                                                           |  | <b>Cancer</b> ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                         | <b>Digestive Health</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Pacemaker/implanted defibrillator ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                      |  | Type: _____                                                                                                                            | Gastrointestinal disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Artificial (prosthetic) heart valve ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                    |  | Date of diagnosis: _____                                                                                                               | G.E. reflux/persistent heartburn (GERD)..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Previous infective endocarditis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                        |  | Chemotherapy: _____                                                                                                                    | Stomach ulcers..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Congenital heart disease (CHD) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                         |  | Radiation treatment: _____                                                                                                             | <b>Eye (Vision) Health</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Unrepaired, cyanotic CHD..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                |  | <b>Blood (Circulatory) Health</b>                                                                                                      | Glaucoma..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Repaired (completely) in last 6 months ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                 |  | Anemia..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                 | <b>Other</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Repaired CHD with residual defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                     |  | Blood transfusion..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                      | Arthritis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Arteriosclerosis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                        |  | If yes, date: _____                                                                                                                    | Chronic pain ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Coronary artery disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                 |  | Hemophilia..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                             | Diabetes (type I or II) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Congestive heart failure..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                |  | High or low blood pressure..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                             | Eating disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Damaged heart valves ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                   |  | <b>Brain (Neurological)/Mental Health</b>                                                                                              | Frequent infections..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Heart attack..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                            |  | Anxiety..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                | Type of infection: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Heart murmur/rhythm disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                           |  | Depression..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                             | Hepatitis, jaundice or liver disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Rheumatic heart disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                 |  | Epilepsy..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                               | Immune deficiency..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Stroke..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                  |  | Mental health disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                               | Kidney problems..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Breathing (Respiratory) Health</b>                                                                                                                                                                                                                                                   |  | Neurological disorders..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                 | Malnutrition ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Asthma (COPD) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                          |  | Post-traumatic stress disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                        | Osteoporosis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Bronchitis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                              |  | Traumatic brain injury or concussion..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                   | Rheumatoid arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Emphysema..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                               |  | <b>Autoimmune Disease</b>                                                                                                              | Sexually transmitted infection (STI)..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Sinus trouble..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                           |  | AIDS or HIV Infection ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                 | Thyroid problems..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Tuberculosis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                            |  | Lupus..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____                                                                                                                                                                                     |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.                                                                                                                                                                                             |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| In the past 30 days, have you:                                                                                                                                                                                                                                                          |  | Yes No ?                                                                                                                               | Yes No ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| had pain or tightness in the chest?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                     |  | found it hard to catch your breath? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                   | experienced vomiting, diarrhea, chills, night sweats or bleeding?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/><br>had migraines or severe headaches? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                |
| coughed up blood or had a cough that lasted longer than 3 weeks? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                       |  | had a high fever (greater than 101.5°F) for no reason?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| been exposed to anyone with tuberculosis?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                               |  | noticed a change in your vision? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| had a rapid or irregular heart beat? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                                                                   |  | fainted for no reason?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.<br>I have answered the above questions completely, accurately and to the best of my ability.<br>Signature of Patient/Legal Guardian: _____ Date: _____ |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| FOR COMPLETION BY DENTIST                                                                                                                                                                                                                                                               |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Comments: _____                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Office Use Only: <input type="checkbox"/> Medical Alert <input type="checkbox"/> Premedication <input type="checkbox"/> Allergies <input type="checkbox"/> Anesthesia                                                                                                                   |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Reviewed by: _____ Date: _____                                                                                                                                                                                                                                                          |  |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |