NAME_____ **DATE**_____

DATE OF BIRTH _____ **WHEN WAS YOUR LAST DENTAL EXAMINATION?** (APPROX) _____

DATE OF LAST HEALTH CARE EXAM (APPROX) _____ **WHAT WAS THIS EXAM FOR?** _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY (PLEASE CIRCLE) YES ◯ OR ◯ NO **IF YES, EXPLAIN:** _____

_____

ARE YOU CURRENTLY RECEIVING MEDICAL CARE? (PLEASE CIRCLE) YES ◯ OR NO ◯ **IF YES, EXPLAIN:** _____

_____

PLEASE LIST ALL THE NAMES AND PHONE NUMBERS OF THE PHYSICIANS WHO ARE CURRENTLY PROVIDING YOU CARE:

1._____
2._____
3._____
4._____

FOR THE FOLLOWING QUESTIONS CIRCLE YES OR NO. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONFIDENTIAL.

HIGH BLOOD PRESSURE/HYPERTENSION	YES ◯	NO ◯	ANEMIA	YES ◯	NO ◯
HEART MURMUR	YES ◯	NO ◯	BLEEDING DISORDER	YES ◯	NO ◯
RHEUMATIC FEVER	YES ◯	NO ◯	KIDNEY DISEASE	YES ◯	NO ◯
MITRAL VALVE PROLAPSE	YES ◯	NO ◯	RENAL DIALYSIS	YES ◯	NO ◯
ANGINA PECTORIS/CHEST PAIN	YES ◯	NO ◯	ORGAN TRANSPLANT	YES ◯	NO ◯
HEART ATTACK	YES ◯	NO ◯	CANCER OR TUMOR	YES ◯	NO ◯
PROSTHETIC (ARTIFICIAL) HEART VALVE	YES ◯	NO ◯	RADIATION THERAPY	YES ◯	NO ◯
IRREGULAR HEART BEAT	YES ◯	NO ◯	CHEMOTHERAPY	YES ◯	NO ◯
PACEMAKER/IMPLANTED DEFIBRILLATOR	YES ◯	NO ◯	EPILEPSY/SEIZURE DISORDER	YES ◯	NO ◯
HEART DISEASE	YES ◯	NO ◯	STOMACH ULCER	YES ◯	NO ◯
HEART OR BYPASS SURGERY	YES ◯	NO ◯	COLITIS/INTESTINAL PROBLEMS	YES ◯	NO ◯
STROKE	YES ◯	NO ◯	ARTHRITIS	YES ◯	NO ◯
EMPHYSEMA	YES ◯	NO ◯	ARTIFICIAL JOINTS	YES ◯	NO ◯
ASTHMA, COPD OR OTHER LUNG DISEASES	YES ◯	NO ◯	SEXUALLY TRANSMITTED DISEASE	YES ◯	NO ◯
DIABETES	YES ◯	NO ◯	HIV/AIDS OR ARC	YES ◯	NO ◯
THYROID DISEASE	YES ◯	NO ◯	TUBERCULOSIS (TB)	YES ◯	NO ◯
LIVER DISEASE	YES ◯	NO ◯	PSYCHIATRIC TREATMENT	YES ◯	NO ◯
HEPATITIS/JAUNDICE	YES ◯	NO ◯	ALLERGY TO LATEX	YES ◯	NO ◯
BLINDNESS/VISION IMPAIRMENT	YES ◯	NO ◯	HEARING IMPAIRMENT	YES ◯	NO ◯
SORE/ENLARGED LYMPH NODES	YES ◯	NO ◯	SLOW-HEALING MOUTH SORES	YES ◯	NO ◯
RECURRENT ILLNESSES	YES ◯	NO ◯	GLAUCOMA	YES ◯	NO ◯

ADD DETAILS TO ANY AILMENT/CONDITION MARKED YES ABOVE: _____

_____

LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION	DOSE	FREQUENCY	REASON FOR TAKING

LIST ANY SUPPLEMENTS YOU TAKE DAILY_____

_____

ALLERGIES – **LIST ALL *MEDICATIONS* THAT HAVE CAUSED ALLERGIC, ADVERSE OR UNTOWARD REACTION AFTER TAKING:** _____

_____

WOMEN: **ARE YOU PREGNANT OR DO YOU THINK YOU MAY BE PREGNANT?** YES ◯ OR ◯ NO
ARE YOU A NURSING MOTHER? YES ◯ OR ◯ NO
ARE YOU TAKING BIRTH CONTROL PILLS? YES ◯ OR ◯ NO

SLEEP DISORDERS

DO YOU HAVE TROUBLE SLEEPING? YES ◯ OR ◯ NO
DO YOU HAVE SLEEP APNEA? YES ◯ OR ◯ NO
DO YOU SNORE? YES ◯ OR ◯ NO
DO YOU HAVE RLS (RESTLESS LEG SYNDROME)? YES ◯ OR ◯ NO

ARE YOU TAKING…

PRE-MEDICATION BEFORE DENTAL TREATMENT? YES ◯ OR ◯ NO
ANY MEDICATION TO TREAT OSTEOPOROSIS? YES ◯ OR ◯ NO
PRESCRIPTION OR NON-PRESCRIPTION DRUGS FOR WEIGHT LOSS? YES ◯ OR ◯ NO

LIST ANY **DIETARY** SUPPLEMENTS YOU ARE TAKING:

1._____ 2._____
3._____ 4. _____

DO YOU CONSUME GRAPEFRUIT JUICE, GRAPEFRUIT, OR GRAPEFRUIT EXTRACT? YES ◯ OR ◯ NO
DO YOU CONSUME CRANBERRY JUICE, CRANBERRIES, OR CRANBERRY EXTRACT? YES ◯ OR ◯ NO

SOCIAL HISTORY

DO YOU SMOKE/CHEW TOBACCO? (PLEASE CIRCLE) YES ◯ OR ◯ NO
HOW LONG HAVE YOU SMOKED OR CHEWED? _____ **HOW OFTEN DO YOU SMOKE/CHEW?** _____
ANY PLANS TO QUIT? (PLEASE CIRCLE) YES ◯ OR ◯ NO **IF YOU HAVE QUIT, WHEN?** _____
DO YOU DRINK ALCOHOL? (PLEASE CIRCLE) YES ◯ OR ◯ NO **HOW OFTEN DO YOU DRINK?** _____
DO YOU USE ANY RECREATIONAL DRUGS? (PLEASE CIRCLE) YES ◯ OR ◯ NO **IF SO, WHAT TYPE?** _____
LAST RECREATIONAL DRUG USE? _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ **PHONE**_____

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OR HYGIENIST OF ANY CHANGE IN MY HEALTH AND/OR MEDICATIONS.

PATIENT SIGNATURE _____ **DATE**_____