

Patient Name _____ Birth Date _____ Preferred Name _____

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)

Name _____ Relationship _____ Phone _____

Physician's Name _____ Date of last visit _____

Pharmacy Name _____ Phone _____

Please check yes or no to indicate if you have had any of the following:

- | | | | | | |
|-------------------------------|--|-----------------------|--|---------------------------------|--|
| AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting/dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial heart valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: A B or C | | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizure Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (with extractions or surgery) | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | Swelling of Feet or ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on Head or Neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, Persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | Paralysis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Women:
 Are you pregnant? Yes No
 Due date _____
 Are you nursing? Yes No
 Are you taking birth control pills? Yes No

Any heart conditions including Bacterial Endocarditis

Have you had congestive heart failure? Yes No Do you have a cardiac defibrillator? Yes No

Any hospital stays Yes No
 Specify _____

Do you or have you ever used any tobacco products? If yes, What: _____ Have you quit? Yes No
 Have you ever had any treatment by a periodontist? _____

MEDICATIONS

Please list medications you are currently taking:
 (Attach additional sheet if necessary)

ALLERGIES

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | |

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing Bisphosphonates? Yes No If Yes: What and When _____

Patient's Signature _____ Date _____

Hygienist/Doctor's Signature _____ Date _____