

Patient Name _____ Nickname _____ Age _____

Name of Physician / and their specialty _____

Most recent physical examination _____ Purpose _____

How would you estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO		YES	NO
1. Hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	25. Digestive disorders (i.e. celiac disease, gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>
2. An allergic reaction to:	<input type="checkbox"/>	<input type="checkbox"/>	26. Osteoporosis/osteopenia (i.e. taking bisphosphonates)	<input type="checkbox"/>	<input type="checkbox"/>
- aspirin, ibuprofen, acetaminophen, codeine	<input type="checkbox"/>	<input type="checkbox"/>	27. Arthritis, rheumatoid arthritis, lupus	<input type="checkbox"/>	<input type="checkbox"/>
- penicillin	<input type="checkbox"/>	<input type="checkbox"/>	28. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
- erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	29. Contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
- tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	30. Head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
- sulfa	<input type="checkbox"/>	<input type="checkbox"/>	31. Epilepsy, convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>
- local anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	32. Neurologic disorders (ADD/ADHD, prion disease)	<input type="checkbox"/>	<input type="checkbox"/>
- fluoride	<input type="checkbox"/>	<input type="checkbox"/>	33. Viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>
- metals (nickel, gold, silver,)	<input type="checkbox"/>	<input type="checkbox"/>	34. Any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>
- latex	<input type="checkbox"/>	<input type="checkbox"/>	35. Hives, skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>
- other	<input type="checkbox"/>	<input type="checkbox"/>	36. STI / STD	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart problems, or cardiac stent within the last six months	<input type="checkbox"/>	<input type="checkbox"/>	37. Hepatitis (type)	<input type="checkbox"/>	<input type="checkbox"/>
4. History of infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
5. Artificial heart valve, repaired heart defect (PFO)	<input type="checkbox"/>	<input type="checkbox"/>	39. Tumor, abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>
6. Pacemaker or implantable defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	40. Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
7. Artificial prosthesis (heart valve or joints)	<input type="checkbox"/>	<input type="checkbox"/>	41. Chemotherapy, immunosuppressive	<input type="checkbox"/>	<input type="checkbox"/>
8. Rheumatic or scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	42. Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
9. High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	43. Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
10. Astroke (taking blood thinners)	<input type="checkbox"/>	<input type="checkbox"/>	44. Antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>
11. Anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	45. Alcohol/street drug use	<input type="checkbox"/>	<input type="checkbox"/>
12. Prolonged bleeding due to a slight cut (INR > 3.5)	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:	<input type="checkbox"/>	<input type="checkbox"/>
13. Emphysema, shortness of breath, sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>	46. Presently being treated for any other illness	<input type="checkbox"/>	<input type="checkbox"/>
14. Tuberculosis, measles, chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	47. Aware of a change in your health in the last 24 hours (i.e. Fever, chills, new cough, or diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>
15. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	48. Taking medication for weight management (i.e. fen-phen)	<input type="checkbox"/>	<input type="checkbox"/>
16. Breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	<input type="checkbox"/>	<input type="checkbox"/>	49. Taking dietary supplements	<input type="checkbox"/>	<input type="checkbox"/>
17. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	50. Often exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>
18. Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	51. Experiencing frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
19. Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	52. A smoker, smoked previously or use smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>
20. Thyroid, parathyroid disease, or calcium deficiency	<input type="checkbox"/>	<input type="checkbox"/>	53. Considered a touchy person	<input type="checkbox"/>	<input type="checkbox"/>
21. Hormone deficiency	<input type="checkbox"/>	<input type="checkbox"/>	54. Often unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>
22. High cholesterol or taking statin drugs	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE - Taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
23. Diabetes (HbA1c =)	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE - Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
24. Stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	57. MALE - Prostate disorders	<input type="checkbox"/>	<input type="checkbox"/>

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____