.

This information is **vital** to allow us to provide appropriate care for you.
PLEASE ANSWER ALL QUESTIONS THOROUGHLY AND TO THE BEST OF YOUR KNOWLEDGE.

Patient Name: _____ Date: _____

MEDICAL INFORMATION

Physician's name and phone number: _____

Date of last physical exam: _____

Emergency contact name and phone number: _____

Relationship to patient: _____

If you currently receive **alternative medical care** such as acupuncture, homeopathy or chiropractic, please list and tell us about the nature of your treatment:

Provider name and phone number: _____

_____

Treatment and reason: _____

_____

Do you regularly take **vitamins or supplements**? If so, please tell us what you are taking and why.

NAME	REASON	HOW OFTEN?	FOR HOW LONG?

Are you currently taking **medications**? Please tell us what you are taking and why.
Include prescriptions and over the counter medications.

NAME & DOSAGE	REASON	HOW OFTEN?	FOR HOW LONG?	Bisphos-phonates	Blood Thinner
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Have you had a serious illness, operation or been hospitalized in the past 5 yrs?

no ☐ yes ☐ (explain) _____

Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexfenfluramine) or Phen-Fen (fenfluramine phentermine combination)?

no ☐ yes ☐ (explain) _____

Have you EVER taken Fosamax, Actonel, Boniva or any other bone loss prevention drugs?

no ☐ yes ☐ (when) _____

Have you been treated or are scheduled to begin treatment with the IV bisphosphonates (Aredia or Zometa)?

no ☐ yes ☐ (date) _____

Are you currently on any chemotherapy?

no ☐ yes ☐ (explain) _____

Have you UNEXPECTEDLY gained or lost more than 10 lbs in the past year?

no ☐ yes ☐ (explain) _____

Have you ever been told you need to take an antibiotic prior to dental visits? (pre-medicate)

no ☐ yes ☐ (explain) _____

List all **allergies and adverse reactions**. Please indicate the nature of the reaction.

			Name of Substance	Reaction
Antibiotic	no ☐	yes ☐		
Sulfa Drugs	no ☐	yes ☐		
Aspirin, Advil (or other anti-inflammatory meds)	no ☐	yes ☐		
Base metal e.g. nickel, lead	no ☐	yes ☐		
Dental Materials e.g. Mercury	no ☐	yes ☐		
Codeine or other pain meds	no ☐	yes ☐		
DENTAL ANESTHETICS (NUMBING)				
Epinephrine	no ☐	yes ☐		
Sulfites	no ☐	yes ☐		
Latex	no ☐	yes ☐		
Other	no ☐	yes ☐		

Have you ever had: (indicate "yes" with a ✓)

CONDITION REQUIRING ANTIBIOTIC PREMEDICATION:

"yes" with ✓

- ☐ artificial (prosthetic) heart valve
- ☐ damaged heart valves (repaired or unrepaired)
- ☐ previous infective endocarditis
- ☐ congenital heart disease
- ☐ artificial joints (hip, knee, elbow, finger, shoulder)
- ☐ Rheumatic fever
- ☐ Rheumatic Heart Disease
- ☐ Shunts
- ☐ Organ transplants

HEART RELATED CONDITIONS:

- ☐ Heart (surgery, disease, attack) (please specify) _____
- ☐ Chest pain (angina)
- ☐ Arteriosclerosis
- ☐ Atrial Fibrillation
- ☐ Congestive heart failure
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Low blood pressure ☐ controlled with meds
- ☐ High blood pressure ☐ controlled with meds
- ☐ Stroke
- ☐ Defibrillator/pacemaker

IMMUNE AND HORMONAL CONDITIONS:

- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Paget's Disease
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Lupus
- ☐ Arthritis
- ☐ Sjogrens
- ☐ Migraine
- ☐ Persistent Swollen Glands in neck
- ☐ Other auto immune disease (please specify)

_____

BLOOD RELATED CONDITIONS:

"yes" with ✓

- ☐ Anemia
- ☐ Abnormal Bleeding
- ☐ Blood Transfusion prior to 1990
- ☐ Hemophilia
- ☐ Sickle Cell Disease

INFECTIOUS DISEASES:

- ☐ Tuberculosis
- ☐ Herpes/Cold Sores/Fever Blister
- ☐ Hepatitis
  ☐ Hep A ☐ Hep B ☐ Hep C ☐ Other
- ☐ HPV
- ☐ AIDS/HIV +
- ☐ Recurrent infection

  list type _____

SYSTEMIC CONDITIONS:

- ☐ Organ transplant (please specify)

  _____
- ☐ Kidney problems
- ☐ Ulcers
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Cancer (please specify)

  _____
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Liver Disease
- ☐ Acid Reflux
- ☐ Glaucoma
- ☐ Gastrointestinal Disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ Sinus Trouble
- ☐ Hay Fever/Allergy/Hives
- ☐ Emphysema
- ☐ Chronic cough

NEUROLOGICAL DISORDERS:

"yes" with ✓

- ☐ Epilepsy or seizures
- ☐ Nervousness/Anxiety
- ☐ Mental Health Disorders (please specify)

_____

- ☐ Depression
- ☐ ADD/ADHD
- ☐ Autism spectrum

OTHER CONDITIONS:

- ☐ Hypoglycemia
- ☐ Eating Disorder (please specify)

_____

- ☐ Sleep Disorder (please specify)

_____

- ☐ Special/Restricted Diet (please specify)

_____

- ☐ Night sweats

USE OF:

ALCOHOL		RECREATIONAL DRUGS
☐	None	☐
☐	Occasional	☐
☐	Moderate	☐
☐	Every day	☐
☐	More than once every day	☐

TOBACCO USE

- ☐ Cigarettes quantity _____ for how long_____
- ☐ Cigars quantity _____ for how long_____
- ☐ Pipe quantity _____ for how long_____
- ☐ Chew/Snuff quantity _____ for how long_____

Are you interested in stopping?

☐ very ☐ somewhat ☐ not interested

Do you have any disease, condition or problem not listed above that you think we should know about?

_____

_____

_____

_____

_____

_____

NOTE: Both Doctor, Hygienist and Patient are encouraged to discuss all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I will notify you of any change in my health or medication. I understand the importance of a truthful health history and that your staff will rely on this information for treating me.

_____

Signature of Patient/Legal Guardian

_____

Signature of Doctor/Hygienist