

The personal information and medical history requested below is to enable me to give you the most consideration of your time and feelings, and to aid in evaluating your dental health thoroughly and completely. It is important for you to give complete answers so that I may give you personal attention. This will become part of your dental record and will be held in strict confidence. **THANK YOU**

PERSONAL INFORMATION Date: _____

Patient Name: _____ Birthdate: ____/____/____

HEALTH HISTORY (Please circle Yes or No or answer question)

Do you consider your medical health good?..... Yes No
 Are you under the care of a physician?..... Yes No
 For what reason? _____

Name of your physician _____

Have you had major surgery?..... Yes No
 When? _____
 For What? _____

Have you been in the hospital recently? Yes No
 When? _____
 For What? _____

Do you have any allergies to medications? Yes No
 To what medications? _____

Do your gums bleed?..... Yes No
 Do you have difficulty chewing your food?..... Yes No
 Have you ever worn braces on your teeth? Yes No

Are you having any discomfort or pain from
 your mouth or face now?..... Yes No
 Lately?..... Yes No

Are you aware of any dental needs now?..... Yes No
 Describe: _____

Are you pregnant now?..... Yes No
 What month? _____

Do you use tobacco?..... Yes No

Please list ALL MEDICATIONS (prescription, over-the-counter, and natural):

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Anemia Yes No
 Arthritis, Gout..... Yes No
 Artificial heart valve/congenital heart condition..... Yes No
 Asthma Yes No
 Bleeding problems/on blood thinners..... Yes No
 Cancer, Leukemia, Tumor, Cyst Yes No
 Cardiac transplant recipient who developed valvulitis? Yes No
 Certain CHD (congenital heart disease): Yes No
If Yes:
 -Unrepaired cyanotic CHD?..... Yes No
 -Palliative shunts and conduits? Yes No
 -First 6 months after completely repaired CHD with
 prosthetic material or device, whether placed by surgery
 or by catheter intervention? Yes No
 -Repaired CHD with residual defects at the site or
 adjacent to the site of a prosthetic device? Yes No
 Diabetes Yes No
 Epilepsy/Seizures..... Yes No
 Glaucoma..... Yes No
 Heart disease, Heart attack..... Yes No
 Hepatitis, Jaundice..... Yes No
 High or Low Blood Pressure..... Yes No
 Joint replacement/Year?..... Yes No
 Kidney or bladder trouble..... Yes No
 Latex allergy..... Yes No
 Lung trouble, Emphysema, T.B, COPD..... Yes No
 Osteoporosis Yes No
 -Are you or have you taken Boniva, Reclast,
 Fosamax, or Actonel?..... Yes No
 -Intravenous bisphosphonate therapy? Yes No
 Previous bouts of infective endocarditis? Yes No
 Prosthetic cardiac valve..... Yes No
 Psychiatric treatment..... Yes No
 Radiation treatments to head/neck area..... Yes No
 Stroke Yes No
 Tested positive for HIV..... Yes No
 Ulcers Yes No

What have you liked the most about any dental office you have been to before? _____

What have you liked the least? _____

Are you happy with your smile?..... Yes No

Are you interested in avoiding bad breath?..... Yes No

Have you ever had any illness or complications associated with any previous dental treatment?..... Yes No

Have you ever had a frightening experience with dentistry?..... Yes No

Have you ever been asked to pre-medicate prior to any dental treatment?..... Yes No

Thank you for your cooperation. If there is any other information of any kind which you feel would be of value to us in any way, please add such information here: _____

PLEASE SIGN BELOW

 Signature Date

 Signature Date

 Signature Date

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THIS OFFICE'S
 NOTICE OF PRIVACY PRACTICES.

 Signature Date