DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

Any allergies or adverse reactions to:

- ☐ general anesthetics, local anesthetics, Novocaine, epinephrine, etc.
- ☐ antibiotics: penicillin, tetracycline, sulpha, or other:
- ☐ pain relievers: aspirin, codeine, NSAIDS, or other:
- ☐ sedatives: anti-anxiety medicine, sleeping pills, barbiturates, or other:
- ☐ foods, flavorings, dyes, toothpastes, vitamins:
- ☐ metals, latex, jewelry, peanuts, or other:

Blood or bleeding disorders or treatment:

- ☐ blood transfusions, anemia, low blood count, low iron
- ☐ abnormal bruising, clotting, nosebleeds, prolonged bleeding, other:

Bone, muscles, joint diseases or treatment:

- ☐ artificial joints, osteoarthritis, rheumatism, bursitis
- ☐ muscle weakness, or other:

Ear, eye, nose, or throat disorders or treatment:

- ☐ hearing loss, ringing in the ears, equilibrium
- ☐ contact lenses, visual changes, glaucoma, detached retina,
- ☐ sinus problems, nose bleeds, mouth breathing
- ☐ sore throat, hoarseness, swollen glands, enlarged tonsils, swollen lymph nodes, other:

Endocrine or hormone problems or treatment:

- ☐ diabetes, goiter or thyroid condition, or other:

Digestive disorders or treatment:

- ☐ hepatitis A, B, or C / pancreatitis, gall bladder
- ☐ high cholesterol, high triglycerides, hyperlipidemia
- ☐ cirrhosis, fatty liver, other liver disease / jaundice
- ☐ persistent diarrhea / black, bloody, or pale stools
- ☐ change in appetite, vomiting, dry mouth, acid reflux, GERD, stomach ulcers
- ☐ inflammatory bowel, Crohn's disease, celiac disease, diverticulitis

Immune system conditions:

- ☐ acquired immune deficiency syndrome (AIDS)
- ☐ AIDS related complex / positive HIV test
- ☐ immune suppression due to disease or chemotherapy
- ☐ autoimmune diseases, lupus, Sjogren's syndrome, rheumatoid arthritis, gout, other:

Infectious diseases or treatments:

- ☐ infectious or contagious disease / MRSA
- ☐ recent known association with any infected person
- ☐ travel history to infectious regions or countries

Nervous system / brain / mental disorders or treatment:

- ☐ fainting, dizziness, numbness, neuritis, neuralgia, neuropathy, tingling
- ☐ paranoia, schizophrenia, dementia, Alzheimer's
- ☐ ADD / ADHD / OCD / ODD / bipolar / autism
- ☐ psychological counseling, mental health treatment
- ☐ stroke, TIA, epilepsy, convulsions, headache
- ☐ nervousness, stress, anxiety, other

Lung/respiratory diseases:

- ☐ tuberculosis, persistent cough, bloody sputum
- ☐ emphysema, COPD, asthma, shortness of breath
- ☐ hay fever, bronchitis, pneumonia, collapsed lung
- ☐ difficulty breathing while lying down, sleep apnea

Skin conditions:

- ☐ blue or purplish spots on skin, mucous membrane, Kaposi's' sarcoma
- ☐ change in skin color, rash, hives, eruptions, welts, ulcerations, neurofibromas, psoriasis
- ☐ slow healing, or other:

Urinary diseases:

- ☐ kidney or urinary disease / dialysis / increased urination
- ☐ urethral discharge / burning on urination / bloody urine / STD / or other:

Heart / vascular / circulation problems or treatment:

- ☐ rheumatic fever, heart murmur, heart valve disease
- ☐ artificial heart valve, pacemaker, defibrillator
- ☐ irregular heart rhythm, palpitations, atrial fibrillation, ventricular tachycardia
- ☐ angina, chest pain, heart attack, congestive heart failure
- ☐ swelling in legs or extremities, phlebitis, deep vein thrombosis, pulmonary embolism
- ☐ high blood pressure / low sodium or low potassium diet
- ☐ congenital heart defects, heart bypass surgery, stents, or other:

Women:

- ☐ puberty / pregnancy / nursing / post-menopausal

General:

- ☐ organ transplant
- ☐ fever / recurring, unexplained fever over 10 days
- ☐ night sweats / weakness / tire easily / chronic pain
- ☐ unexplained weight change of 10 pounds or more
- ☐ series of needles, shots, or injections
- ☐ tumors, growths, cysts, cancers / radiation therapy, chemotherapy
- ☐ immediate family members with the following: diabetes, high cholesterol, hyperlipidemia, heart disease, blood disorders, hypertension, clotting disorders, muscle disorders, nervous system disorders, mental disorders, autoimmune disease, gum disease

Any of the following drugs used in the past 2 weeks?

- ☐ antibiotics or anti-virals
- ☐ anti-inflammatory / aspirin / pain relievers
- ☐ blood thinners / anticoagulants
- ☐ antihistamine / allergy / decongestant / cold medicine
- ☐ cortisone, steroids, thyroid medicine, insulin,
- ☐ hormones, birth control pills
- ☐ heart drugs, digitalis, nitroglycerine
- ☐ muscle relaxants, sedatives, tranquilizers, anti-anxiety medicine, sleep aids
- ☐ hyperactivity medicine

Substance abuse / addiction:

- ☐ tobacco use: inhaled, chewed, rubbed
- ☐ three or more alcoholic drinks per day
- ☐ recreational drug use, IV drug use, inhalants

Dental conditions

- ☐ bleeding or sore gums / gum disease / gum surgery
- ☐ family history of gum disease or early tooth loss
- ☐ abscessed teeth / root canal therapy
- ☐ jaw pain, clicking, popping, teeth grinding, TMD clenching, difficulty opening or closing jaw, treatment
- ☐ frequent mouth blisters or ulcers / blemishes on cheeks, gums, or tongue
- ☐ dry mouth, unexplained burning sensation, numbness, tingling
- ☐ unpleasant taste or bad breath odor
- ☐ sensitive teeth to hot, cold, biting pressure
- ☐ teeth that are loose or shifting / changes in bite
- ☐ discolored teeth or fillings, inherited enamel disorders
- ☐ food impactions between teeth
- ☐ tooth extractions / mouth surgery
- ☐ mouth, face, or head injury or surgery
- ☐ crown, caps, veneers, or fixed bridgework
- ☐ implant supported crowns or fixed bridgework
- ☐ pins, posts,
- ☐ mouth guards
- ☐ crooked or crowded teeth
- ☐ space maintainers, orthodontic braces, retainers
- ☐ congenitally missing teeth
- ☐ lip or tongue piercings
- ☐ complete dentures / removable partial dentures immediate dentures
- ☐ implant supported dentures or removable dentures

Has there been any other MEDICAL problems not listed above that we should be aware of? Explain:

Has there been any other DENTAL problems not listed above that we should be aware of? Explain:

Signature: patient, parent or guardian: _____ Date _____

PLEASE PRINT CLEARLY AND COMPLETE ALL QUESTIONS ON THIS FORM.

Information on this form is required to provide safe and efficient dental treatment; it will remain confidential and will not be released without your written authorization except to other health care practitioners or dental benefit providers directly involved with your care as part of normal healthcare operations in accords with the privacy policies of this office and your HIPAA preferences. All questions must be answered; deliberate omissions or falsifications may jeopardize your health and can result in dental treatment being denied. Additionally, you must make this office aware of future changes in health and medications.

PATIENT NAME: **TODAYS DATE:**

BIOSTATISTICAL DATA:

BIRTHDATE: AGE: GENDER: RACE: WEIGHT: HEIGHT:

PREVIOUS DENTIST: PHONE: ADDRESS:

DENTAL SPECIALISTS: PHONE: ADDRESS:

PRIMARY-CARE PHYSICIAN: PHONE: ADDRESS:

SPECIALTY-CARE PHYSICIANS: PHONE: ADDRESS:

List all current and daily medications, over the counter medications, vitamins, or supplements and their dosages:

Have you seen a medical doctor in the past 2 years? Explain.

Have you ever been hospitalized or had a serious illness? Explain.

Are you anxious or nervous about dental treatment?

Circle the reason for your visit today? emergency examination / routine second opinion

How often do you have dental examinations? 3 mo. 6 mo. yearly emergencies only never

Last dental examination date? Last tooth cleaning date? Last dental x-ray exam date?

How often do you brush your teeth? How often do you floss?

List any other dental aids, rinses, or devices that you use:

Are you satisfied with the appearance of your teeth?