

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Yes No DK

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date Treatment began: _____

Allergies. Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.

Yes No DK

Local anesthetics ☐ ☐ ☐

Aspirin ☐ ☐ ☐

Penicillin or other antibiotics ☐ ☐ ☐

Barbiturates, sedatives, or sleeping pills ☐ ☐ ☐

Sulfa drugs ☐ ☐ ☐

Codeine or other narcotics ☐ ☐ ☐

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?

Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐

Number of weeks: _____

Taking birth control pills or hormonal replacement? ☐ ☐ ☐

Nursing? ☐ ☐ ☐

Yes No DK

Metals ☐ ☐ ☐

Latex (rubber) ☐ ☐ ☐

Iodine ☐ ☐ ☐

Hay fever/seasonal ☐ ☐ ☐

Animals ☐ ☐ ☐

Food ☐ ☐ ☐

Other ☐ ☐ ☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes No DK

Artificial (prosthetic) heart valve ☐ ☐ ☐

Previous infective endocarditis ☐ ☐ ☐

Damaged valves in transplanted heart ☐ ☐ ☐

Congenital heart disease (CHD)

Unrepaired, cyanotic CHD ☐ ☐ ☐

Repaired (completely) in last 6 months ☐ ☐ ☐

Repaired CHD with residual defects ☐ ☐ ☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes No DK

Cardiovascular disease ☐ ☐ ☐

Angina ☐ ☐ ☐

Arteriosclerosis ☐ ☐ ☐

Congestive heart failure ☐ ☐ ☐

Damaged heart valves ☐ ☐ ☐

Heart attack ☐ ☐ ☐

Heart murmur ☐ ☐ ☐

Low blood pressure ☐ ☐ ☐

High blood pressure ☐ ☐ ☐

Other congenital heart defects ☐ ☐ ☐

Yes No DK

Mitral valve prolapse ☐ ☐ ☐

Pacemaker ☐ ☐ ☐

Rheumatic fever ☐ ☐ ☐

Rheumatic heart disease ☐ ☐ ☐

Abnormal bleeding ☐ ☐ ☐

Anemia ☐ ☐ ☐

Blood transfusion ☐ ☐ ☐

If yes, date: _____

Hemophilia ☐ ☐ ☐

AIDS or HIV infection ☐ ☐ ☐

Arthritis ☐ ☐ ☐

Yes No DK

Autoimmune disease ☐ ☐ ☐

Rheumatoid arthritis ☐ ☐ ☐

Systemic lupus erythematosus ☐ ☐ ☐

Asthma ☐ ☐ ☐

Bronchitis ☐ ☐ ☐

Emphysema ☐ ☐ ☐

Sinus trouble ☐ ☐ ☐

Tuberculosis ☐ ☐ ☐

Cancer/Chemotherapy/ Radiation Treatment ☐ ☐ ☐

Chest pain upon exertion ☐ ☐ ☐

Chronic pain ☐ ☐ ☐

Diabetes Type I or II ☐ ☐ ☐

Eating disorder ☐ ☐ ☐

Malnutrition ☐ ☐ ☐

Gastrointestinal disease ☐ ☐ ☐

G.E. Reflux/persistent heartburn ☐ ☐ ☐

Ulcers ☐ ☐ ☐

Thyroid problems ☐ ☐ ☐

Stroke ☐ ☐ ☐

Yes No DK

Glaucoma ☐ ☐ ☐

Hepatitis, jaundice or liver disease ☐ ☐ ☐

Epilepsy ☐ ☐ ☐

Fainting spells or seizures ☐ ☐ ☐

Neurological disorders ☐ ☐ ☐

If yes, specify: _____

Sleep disorder ☐ ☐ ☐

Do you snore? ☐ ☐ ☐

Mental health disorders ☐ ☐ ☐

Specify: _____

Recurrent Infections ☐ ☐ ☐

Type of infection: _____

Kidney problems ☐ ☐ ☐

Night sweats ☐ ☐ ☐

Osteoporosis ☐ ☐ ☐

Persistent swollen glands in neck ☐ ☐ ☐

Severe headaches/migraines ☐ ☐ ☐

Severe or rapid weight loss ☐ ☐ ☐

Sexually transmitted disease ☐ ☐ ☐

Excessive urination ☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone: Include area code

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

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and 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 understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:

Date:

Signature of Dentist:

Date:

FOR COMPLETION BY DENTIST

Comments: