

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?		Yes	No	?
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim),			
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-			
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs),			
Hay fever/seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dapson, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide			
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(Microzide) and furosemide (Lasix)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please describe any "Yes" answers and include information about your experience.			
Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / / What is your normal blood pressure (systolic, diastolic)?

Please use an "X" to mark your answers to the following questions.

Are you in good physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently being seen or treated by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a doctor or previous dentist recommended that you take antibiotics before having dental work done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a heart valve replacement or heart surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an organ or bone marrow/stem cell transplant ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled internationally within the last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a fever (100.4°F or above) in the last 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you answered yes to any of the above, please explain: _____			

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?			
	Yes	No	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur/rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing (Respiratory) Health			
Asthma (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer			
Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of diagnosis: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation treatment: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood (Circulatory) Health			
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain (Neurological)/Mental Health			
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-traumatic stress disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic brain injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease			
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Health			
Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.E. reflux/persistent heartburn (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye (Vision) Health			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other			
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (type I or II)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of infection: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted infection (STI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any disease, condition, or problem that's not listed here that you think I should know about? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?		Yes	No	?
had pain or tightness in the chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	found it hard to catch your breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
coughed up blood or had a cough that	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	had a high fever (greater than 101.5°F) for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lasted longer than 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	no reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
been exposed to anyone with tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	noticed a change in your vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
had a rapid or irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fainted for no reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.
 Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: Medical Alert Premedication Allergies Anesthesia

Reviewed by: _____ Date: _____