welcome

Patient's name _____
Last First Initial Date of birth

Social Security # Occupation Home phone # Work phone #

Circle the appropriate answer. If you are unsure of any answer, please write "Don't know" on the line after the question.

1. Physician's name_____
   Address _____
2. Are you under a physician's care?
   Since when?_____ Why?_____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? ..... YES NO
   (If yes, please list medications in column on right.)
5. Do you routinely take herbal supplements? ..... YES NO
6. Are you allergic to any medications or substances? ..... YES NO
7. Do you have any other allergies? ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Do you have a pacemaker or an artificial heart valve or any heart murmurs? ..... YES NO
10. Do you have any artificial joint/prosthesis? ..... YES NO
11. Do you have any blood disorders, such as anemia, leukemia, etc.? ..... YES NO
12. Are you sensitive to any metals or latex? ..... YES NO
13. Do you use any birth control medication or is there any possibility of being pregnant? ..... YES NO
14. Have you ever been treated for or been told you might have heart disease or rheumatic fever? ..... YES NO
15. Have you ever had a serious illness or major surgery or hospitalization? ..... YES NO
    If so, explain _____
16. Have you ever had radiation treatment or chemo treatment for tumor, growth or other condition? ..... YES NO
17. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
18. Have you ever bled excessively after being cut or injured? ..... YES NO
19. Do you have any stomach, kidney or liver problems? ..... YES NO
20. Are you a diabetic? ..... YES NO
21. Do you have asthma? ..... YES NO
22. Do you have epilepsy or seizure disorders? ..... YES NO
23. Do you or have you had venereal disease or tested positive for HIV or have AIDS? ..... YES NO
24. Have you had or do you test positive for hepatitis? ..... YES NO
25. Do you or have you had tuberculosis (TB)? ..... YES NO
26. Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
27. Do you consume alcoholic beverages? ..... YES NO
28. Do you habitually use controlled substances? ..... YES NO
29. Do you have high blood pressure? ..... YES NO
    Do you snore? ..... YES NO
    Did anyone ever see you gasping for air when you were sleeping? ..... YES NO
    Do you use a CPAP or have you been told to use one? ..... YES NO
30. Do you have a thyroid disorder? ..... YES NO
31. Do you have any disease condition or problem not listed? If so, explain _____
    _____
32. Is there anything we should know about your health that we have not covered in this form?
    _____
33. Would you like to speak to the Doctor privately about any problem?
34. How did you hear about our office? _____
35. Who was your last dentist? _____
36. How many years ago was your last dental visit? _____
37. Is there anything you want to change about your mouth? _____
    _____

COMMENTS

I certify that the above information is complete and accurate.

Patient's/Guardian's signature _____ **Date** _____

Dentist's signature _____ **Date** _____

ANEST.

MED. ALERT

MEDICAL HISTORY