Patient Name: Date of Birth:

Physicians (please list your family physician and any medical specialists you see at least once a year):

Name Address City Phone # Specialty

Approximate date of last physical examination:

Medications that you take on a regular basis:

Do you have (or have you had) any of the following?:

Yes No Allergic reaction to (select all that apply)

 Latex Penicillin Aspirin Codeine

Narcotics Acetaminophen Local Anesthetics Other

Yes No Heart attack or heart disease (date )

Yes No Heart surgery (date )

Yes No Stroke (date )

Yes No Mini stroke/TIA (date )

Yes No High blood pressure

Yes No Congestive heart failure

Yes No Angina (chest pains)

Yes No Irregular heart beat

Yes No Artificial heart valve

Yes No Rheumatic fever, rheumatic heart disease

Yes No Bacterial endocarditis (SBE)

Yes No Congenital heart disease

Yes No Immunosuppressive condition (select all that apply)

 Steroid therapy (e.g. Prednisone) Radiation therapy Chemotherapy

 SLE (Lupus) Rheumatoid arthritis HIV

Organ transplant Spleen removed Other

Yes No Artificial implants or devices (select all that apply)

 Hip Knee Ankle Shoulder Other

 Date(s) placed:

Yes No Other artificial implants or devices

Yes No Bleeding problem, anemia, other blood diseases

Yes No Diabetes

Yes No Thyroid disease

Yes No Nervous system disease or seizures

Yes No Stomach (i.e. ulcer) or intestinal diseases (Crohn’s, IBS, etc.)

Yes No Kidney disease

Yes No Hepatitis (A, B, C, or D)

Yes No Other liver disease

Yes No Arthritis (Osteo or Rheumatoid)

Yes No Other muscle or joint disease

Yes No Asthma

Yes No Tuberculosis

Yes No Other lung disease

Yes No Mental health condition – specifically:

Yes No Physical or mental disabilities that may require special care

 Describe:

Yes No Do you have or have you ever been treated for cancer?

 If you answered yes, how was it treated?

Yes No Do you have any diseases, conditions, or problem not listed here?

 Describe:

Yes No Have you ever been hospitalized or had surgery?

 Describe:

Yes No Dr you have any undiagnosed symptoms?

 Describe:

Yes No Are you, or have you ever been addicted to a chemical substance?

 (examples: alcohol, prescription drugs, heroin, meth, cocaine, other)

Yes No Do you smoke tobacco products?

 How much and how often?

Yes No Do you regularly consume alcoholic products?

 How much and how often?

Yes No Do you regularly take herbal medicines or dietary supplements? (select all that apply)

 Echinacea Garlic Ginger Kava Valerian Feverfew

 Ginkgo Ginseng St. John’s Wort Vitamin E Other:

Yes No Have you received injections or taken medication for past osteoporosis therapy or bone cancer?

 (Examples are: Fosamax, Boniva, Prolia, etc.)

Yes No Have you taken steroids (cortisone, etc.) in the past 12 months? Date:

Yes No Have you had a prolonged illness and hospitalization experience during the past 5 years?

 Describe:

Females

Yes No Are you or could you be pregnant

Yes No Do you take birth control pills?

Yes No Have you completed Menopause?

Yes No Do you have hormone replacement (HRT)?

Yes No Are you nursing?

Other Health information of concern?

**At each dental appointment please advise us of changes in your health status.**

**(e.g. pregnancy, cardiac distress, hospitalization, prolonged illness,…)**

**Patient signature: Date:**

**Thank you for helping us to help you**

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| --- |
| **Reviewed by: Premed. indicated? Date:**  |