

PATIENT NAME _____ DATE _____

Although dental personnel treat the area in and around your mouth, your mouth is part of your entire body. Ongoing research is finding many links between oral disease and systemic health. Health problems you may have or medications you may be taking could have an important interrelationship with oral conditions that may exist and the dental care you will receive. Thank you for taking the time to answer the following questions carefully.

MEDICAL HISTORY

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE? YES NO WHY? _____ WHO? _____ PHONE# _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION? YES NO WHY? _____ WHEN? _____

HAVE YOU EVER HAD A SERIOUS INJURY TO YOUR HEAD OR NECK? YES NO WHEN? _____ DISCUSS _____

ARE YOU ON A SPECIAL DIET? YES NO DISCUSS _____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? PLEASE CHECK THE APPROPRIATE BOXES BELOW:

ASPIRIN PENICILLIN CODEINE ACRYLIC METAL LATEX RUBBER LOCAL ANESTHETICS IODINE OTHER _____

WOMEN, ARE YOU CURRENTLY: PREGNANT/TRYING TO GET PREGNANT NURSING TAKING ORAL CONTRACEPTIVES

DO YOU NOW, OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS:

CORTISONE/STEROIDS BISPHOSPHONATES (AREIDIA, RECLAST, ZOMETA, FOSAMAX, ACTONEL, BONIVIA, OR ANY OTHER)

ARE YOU CURRENTLY TAKING ANY MEDICATIONS, EITHER PRESCRIPTIONS, OVER THE COUNTER DRUGS, VITAMINS, HERBAL SUPPLEMENTS, OR OTHER DRUGS?

IF SO, PLEASE LIST EACH MEDICATION, YOUR DAILY DOSAGE, HOW IT IS TAKEN, AND WHY YOU TAKE IT BELOW:

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

CARDIOVASCULAR DISORDERS	<input type="checkbox"/> NONE ↓	INFECTIOUS DISEASES	<input type="checkbox"/> NONE ↓	ALLERGIC DISORDERS	<input type="checkbox"/> NONE ↓	BLOOD DISORDERS	<input type="checkbox"/> NONE ↓
HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEPATITIS A (INFECTIOUS)	<input type="checkbox"/> YES <input type="checkbox"/> NO	ANAPHYLAXIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	BRUISE EASILY	<input type="checkbox"/> YES <input type="checkbox"/> NO
LOW BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEPATITIS B OR C	<input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGIES (MEDICINES)	<input type="checkbox"/> YES <input type="checkbox"/> NO	ANEMIA	<input type="checkbox"/> YES <input type="checkbox"/> NO
ANGINA/CHEST PAIN	<input type="checkbox"/> YES <input type="checkbox"/> NO	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGIES (POLLEN/DUST)	<input type="checkbox"/> YES <input type="checkbox"/> NO	EXCESSIVE BLEEDING	<input type="checkbox"/> YES <input type="checkbox"/> NO
ARTIFICIAL HEART VALVE	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIV POSITIVE	<input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGIES (OTHER)	<input type="checkbox"/> YES <input type="checkbox"/> NO	SICKLE CELL DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
BACTERIAL ENDOCARDITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	HAY FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEMOPHILIA	<input type="checkbox"/> YES <input type="checkbox"/> NO
CONGENITAL DISORDER	<input type="checkbox"/> YES <input type="checkbox"/> NO	GENITAL HERPES	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIVES OR RASH	<input type="checkbox"/> YES <input type="checkbox"/> NO	RECENT BLOOD TRANSFUSION	<input type="checkbox"/> YES <input type="checkbox"/> NO
CORONARY STENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	SHINGLES	<input type="checkbox"/> YES <input type="checkbox"/> NO	ORTHOPEDIC DISORDERS	<input type="checkbox"/> NONE ↓	KIDNEY/LIVER DISORDERS	<input type="checkbox"/> NONE ↓
HEART ATTACK/FAILURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	SCARLET FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO	ARTHRITIS/GOUT	<input type="checkbox"/> YES <input type="checkbox"/> NO	KIDNEY PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART DISEASE/SURGERY	<input type="checkbox"/> YES <input type="checkbox"/> NO	RHEUMATIC FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO	ARTIFICIAL JOINT	<input type="checkbox"/> YES <input type="checkbox"/> NO	RENAL DIALYSIS	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART MURMUR/DEFECT	<input type="checkbox"/> YES <input type="checkbox"/> NO	COLD SORES/FEVER BLISTERS	<input type="checkbox"/> YES <input type="checkbox"/> NO	PAIN IN JAW JOINTS	<input type="checkbox"/> YES <input type="checkbox"/> NO	LIVER DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART PACE MAKER	<input type="checkbox"/> YES <input type="checkbox"/> NO	NEUROLOGICAL DISORDERS	<input type="checkbox"/> NONE ↓	RHEUMATISM	<input type="checkbox"/> YES <input type="checkbox"/> NO	YELLOW JAUNDICE	<input type="checkbox"/> YES <input type="checkbox"/> NO
IRREGULAR HEART BEAT	<input type="checkbox"/> YES <input type="checkbox"/> NO	STROKE	<input type="checkbox"/> YES <input type="checkbox"/> NO	OSTEOPOROSIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER	<input type="checkbox"/> NONE ↓
MITRAL VALVE PROLAPSE	<input type="checkbox"/> YES <input type="checkbox"/> NO	CONVULSIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO	OSTEONECROSIS OF JAW	<input type="checkbox"/> YES <input type="checkbox"/> NO	ALCOHOLISM	<input type="checkbox"/> YES <input type="checkbox"/> NO
RESPIRATORY DISORDERS	<input type="checkbox"/> NONE ↓	EPILEPSY OR SEIZURES	<input type="checkbox"/> YES <input type="checkbox"/> NO	CANCER	<input type="checkbox"/> NONE ↓	DRUG ADDICTION	<input type="checkbox"/> YES <input type="checkbox"/> NO
LUNG DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	FAINTING OR DIZZINESS	<input type="checkbox"/> YES <input type="checkbox"/> NO	CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO	COCHLEAR IMPLANTS	<input type="checkbox"/> YES <input type="checkbox"/> NO
BREATHING PROBLEM	<input type="checkbox"/> YES <input type="checkbox"/> NO	NERVOUSNESS	<input type="checkbox"/> YES <input type="checkbox"/> NO	TUMORS/GROWTHS	<input type="checkbox"/> YES <input type="checkbox"/> NO	EXCESSIVE THIRST	<input type="checkbox"/> YES <input type="checkbox"/> NO
SHORTNESS OF BREATH	<input type="checkbox"/> YES <input type="checkbox"/> NO	ALZHEIMER'S DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	CHEMOTHERAPY	<input type="checkbox"/> YES <input type="checkbox"/> NO	GLAUCOMA	<input type="checkbox"/> YES <input type="checkbox"/> NO
FREQUENT COUGH	<input type="checkbox"/> YES <input type="checkbox"/> NO	PSYCHIATRIC CARE	<input type="checkbox"/> YES <input type="checkbox"/> NO	RADIATION TREATMENTS	<input type="checkbox"/> YES <input type="checkbox"/> NO	NIGHT SWEATS	<input type="checkbox"/> YES <input type="checkbox"/> NO
ASTHMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	FREQUENT HEADACHES	<input type="checkbox"/> YES <input type="checkbox"/> NO	METABOLIC/HORMONAL DISORDERS	<input type="checkbox"/> NONE ↓	RECENT WEIGHT LOSS	<input type="checkbox"/> YES <input type="checkbox"/> NO
BLOODY SPUTUM	<input type="checkbox"/> YES <input type="checkbox"/> NO	GASTROINTESTINAL DISORDERS	<input type="checkbox"/> NONE ↓	DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	SWELLING OF LIMBS	<input type="checkbox"/> YES <input type="checkbox"/> NO
EMPHYSEMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	STOMACH/INTESTINAL DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	HYPOGLYCEMIA	<input type="checkbox"/> YES <input type="checkbox"/> NO	TATTOOS/BODY PIERCING	<input type="checkbox"/> YES <input type="checkbox"/> NO
TUBERCULOSIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	ULCERS	<input type="checkbox"/> YES <input type="checkbox"/> NO	THYROID DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	UNEXPLAINED FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO
SINUS TROUBLE	<input type="checkbox"/> YES <input type="checkbox"/> NO	FREQUENT DIARRHEA	<input type="checkbox"/> YES <input type="checkbox"/> NO	PARATHYROID DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO		

HAVE YOU HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? YES NO WHAT ? _____

HAVE YOU EVER NEEDED ANTIBIOTIC PREMEDICATION FOR DENTAL PROCEDURES? YES NO WHY? _____

DO YOU WISH TO TALK TO THE DOCTOR PRIVATELY ABOUT ANY PROBLEM? YES NO

PATIENT SIGNATURE (OR RESPONSIBLE PARTY) _____ DATE _____

REVIEWED BY DOCTOR _____ DATE _____

