

Patient's Name _____

Date of Birth _____

Medical Doctor Name _____

Phone _____

Please answer the following question as completely as possible (circle YES or NO)

1. Do you consider yourself to be in good health?	YES	NO
2. Are you now or have you been under a physician's care within the past year?	YES	NO
If YES, specify condition being treated:	YES	NO
3. Do you take any medications, including birth control pills?		
If YES, specify name and purpose of medication:	YES	NO
4. Do you have, or have you ever had any heart or blood problems?	YES	NO
5. Have you ever been told you have a heart murmur?	YES	NO
6. Do you require antibiotic pre-medication for a heart condition, artificial valve, or artificial joint?	YES	NO
7. Do you have, or have you ever had high blood pressure?	YES	NO
8. Do you bleed or bruise easily?	YES	NO
9. Have you ever been diagnosed as being HIV positive or having AIDS?	YES	NO
10. Have you ever had hepatitis or liver disease?	YES	NO
11. Have you ever had: Rheumatic Fever <input type="checkbox"/> Asthma <input type="checkbox"/> any Blood Disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Rheumatism <input type="checkbox"/> Arthritis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Immune System Disease <input type="checkbox"/> Other Disease <input type="checkbox"/>	YES	NO
12. Have you ever had an unusual reaction, or are you allergic to any of the following drugs: Penicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Acetaminophen <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Codeine <input type="checkbox"/> Barbiturates <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Other <input type="checkbox"/>	YES	NO
13. Are you subject to fainting?	YES	NO
14. Have you ever had any severe reaction to dental treatment or local anesthetics?	YES	NO
15. Are you allergic to any local anesthetics?	YES	NO
16. Do you have any other allergies? If YES, please explain	YES	NO
17. Have you ever had a nervous breakdown or undergone psychiatric treatment?	YES	NO
18. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?	YES	NO
19. Women: Are you pregnant?	YES	NO
20. Are you now in pain?	YES	NO
21. How long ago did you last see a dentist?		
22. Who was your previous dentist?		
23. Do you think that your teeth are affecting your general health in any way?	YES	NO
24. Do you have or have you ever had bleeding or sensitive gums?	YES	NO
25. Have you ever taken Phen-Fen or similar appetite suppressants?	YES	NO
If YES, have you seen your physician or cardiologist for a cardiac evaluation?	YES	NO

DENTAL INFORMATION

YES	NO	Do you have any pain in or near your ears?	YES	NO	Do you have or have you had bleeding gums?
YES	NO	Do you habitually clench your teeth during the day or night?	YES	NO	Have you ever been instructed in caring for your gums?
YES	NO	Are any areas of your mouth sore or sensitive to sweets, hot, cold, or chewing problems?	YES	NO	Have you ever been instructed in the prevention of decay?
YES	NO	Any reactions or allergic symptoms to novocaine or xylocaine?	YES	NO	Have you ever had a series of full x-rays in the past year?
YES	NO	Any difficult extractions? Any prolonged bleeding following extractions?	YES	NO	Do you have any present dental complaints?