Have you ever had any of the following? ***Please select one.***

Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Glaucoma	☐	☐	Osteoporosis
☐	☐	Allergies	☐	☐	Grind or Clench Teeth	☐	☐	Pacemaker
☐	☐	Anemia	☐	☐	Hay Fever	☐	☐	Are you currently pregnant or (any chance of) Due Date:_____
☐	☐	Angina	☐	☐	Heart Attack	☐	☐	Are you currently nursing?
☐	☐	Arthritis	☐	☐	Heart Surgery	☐	☐	Radiation Treatment
☐	☐	Artificial Joints/Implants	☐	☐	Heart Palpitations	☐	☐	Respiratory Problems
☐	☐	Asthma	☐	☐	Heart Valve	☐	☐	Rheumatic Fever
☐	☐	Blood Disease	☐	☐	Head Injuries	☐	☐	Rheumatism
☐	☐	Blood Transfusion	☐	☐	Heart Disease	☐	☐	Seizures/Convulsions
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Sinus Problems
☐	☐	Chronic Cough	☐	☐	Hepatitis	☐	☐	Stomach Problems
☐	☐	Clicking/Popping of Jaw	☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Depressed Immune System	☐	☐	HIV	☐	☐	Thyroid Disease
☐	☐	Diabetes	☐	☐	Jaundice	☐	☐	Tuberculosis
☐	☐	Dizziness	☐	☐	Kidney Disease	☐	☐	Tumors
☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐	Ulcers
☐	☐	Epilepsy	☐	☐	Lung Disease	☐	☐	Venereal Disease
☐	☐	Excessive Bleeding	☐	☐	Mental Disorders	☐	☐	Other:_____
☐	☐	Fainting	☐	☐	Nervous Disorders	☐	☐	

Do you need to PreMedicate prior to Dental Appointment? ☐ Yes ☐ No

Are you using any of the following? Please check those that apply:

☐ Antibiotics ☐ Blood Thinners ☐ Aspirin / Motrin, Aleve ☐ Tranquilizers
☐ High Blood Pressure ☐ Steroids/ Cortisone ☐ Ibuprofen ☐ Insulin/ Anti-Diabetic Drugs
☐ Medication ☐ Heart Drugs (Digitalis/Inderal etc.) ☐ Phen Phen

Please list any other medications you are taking including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____

_____

_____

Have you ever used any of the following? Please check those that apply:

☐ Biosphosphnates (for Oseoporosis/Cancer) ☐ Fosamax, Actonel, Boniva, Aredia, or Zometa ☐ Phen-Phen

Are you allergic to or have you had an adverse reaction to any of the following? Please check those that apply:

☐ Local Anesthesia/ Novocaine ☐ Penicillin / Antibiotics ☐ Sedatives / Barbiturates ☐ Aspirin/ Ibuprofen
☐ Codeine/ Pain killers ☐ Latex/Rubber ☐ OTHER: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you smoke or chew Tobacco products? ☐ Yes ☐ No
  If yes, How much per day: _____
- Have you ever had past history of Alcohol, Chemical dependency or Emotional disorder? ☐ Yes ☐ No
- Have you or an immediate family member ever had any problems associated with intravenous anesthesia ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- If you are using oral contraceptives, it is important to understand that antibiotics (and some other medications) may Interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control.
- Do you wish to talk to the doctor privately about anything? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Patient Signature _____ Date_____

Dentist Signature _____ Date _____