PATIENT'S NAME _____ DATE OF BIRTH _____

PHYSICIAN'S NAME _____ PHYSICIAN'S ADDRESS _____ PHYSICIAN'S TELEPHONE _____

MOST RECENT VISIT TO PHYSICIAN _____ REASON _____

HOW WOULD YOU ASSESS YOUR GENERAL HEALTH? o GOOD o FAIR o POOR

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	Yes	No
Are you currently seeing a physician for treatment of a recent or ongoing medical condition?	o	o
Have you been hospitalized within the last year? If yes, explain:	o	o
Have you had a serious illness or operation within the last year? If yes, explain:	o	o
Have you ever had any serious medical trouble Associated with any dental experience? If yes, explain:	o	o
Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? If yes, explain:	o	o

Do you now or have you had any of the following cardio-vascular diseases? yes o **no** o

If yes, check any that apply:

o Heart disease
o Hardening of the arteries
o Heart attack
o Stroke
o Coronary bypass
o Heart murmur
o Angina
o Congestive heart failure
o Mitral valve prolapse
o Rheumatic fever or rheumatic heart disease
o Congenital heart defects
o Prosthetic (artificial) heart valves
o Pacemaker. If yes, date of placement _____
o High blood pressure
o High cholesterol
o Shortness of breath after mild exercise
o Shortness of breath when you lie down
o Swelling of ankles
o Chest pain upon exertion
o Abnormal bleeding or extended clotting time
o Frequent or unexpected nose bleeds
o Currently taking Fosamax, Boniva or Actonel, If yes, how long? _____
o Previously taken Fosamax, Boniva or Actonel, If yes, how long? _____

Diabetes yes o **no** o

If yes, do you require insulin?
Type _____ Dose_____

Artificial joint(s) yes o **no** o

If yes, which joint(s)
_____

Hepatitis yes o **no** o

If yes, check type:
o Type A
o Other
o Type B
o Non-specific type
o Type C
o Don't know
o Required a blood transfusion
If yes, when _____
o HIV positive
o Have reason to suspect you have been exposed to the HIV virus
If yes when? _____

Tuberculosis (TB) **yes** o **no** o

o Had a TB test?
o A cough lasting more than three weeks
o Cough up blood

Check any that apply;

o Allergies
o Alzheimer's Disease
o Anemia
o Angina
o Asthma
o Arthritis
o Autoimmune Disorder
o Blood Disorder
o Cancer
o Chemo Therapy
o Chronic Sinusitis
o Cirrhosis of liver
o Depression
o Diabetes
o Drug/Alcohol Treatment
o Eating Disorder
o Epilepsy/Seizures
o Glaucoma
o Heart Disease
o Herpes
o HIV / AIDS
o Jaundice
o Joint Replacement
o Kidney Disease
o Organ Transplant
o Osteoporosis
o Parkinson's Disease
o Radiation Treatment
o Severe Headaches
o Sexually Transmitted Disease
o Skin Problems
o Tuberculosis
o Ulcers

	Yes	No
Do you consider yourself **currently** under an ***abnormally*** high amount of stress?	o	o
Have you had an unexplained or unplanned weight loss recently?	o	o

When was your last complete physical exam with your physician, including blood tests? _____

Do you now or have you ever smoked?	o	o
If you currently smoke, how much? _____		
If you were a smoker, when did you quit? _____		
Do you chew tobacco?	o	o
If yes, how often? _____		
Do you drink alcohol?	o	o
If yes, how much? _____		

W O M E N O N L Y

	Yes	No
Are you currently pregnant?	o	o
If yes, expected delivery date _____		
Do you have regular gynecological checkups?	o	o
Have you reached menopause?	o	o
Are you on hormone replacement therapy?	o	o
Have you had a mammogram?	o	o
Date _____		

Are you *ALLERGIC* to any of the following, please circle or list medication (get hives, a rash, have trouble breathing, etc.):

o Antibiotics (penicillin, tetracycline) _____

o Local dental anesthetics (novocain) _____

o Codeine

o Aspirin

o Barbiturates or sedatives _____

o Tranquilizers _____

o Latex

o Others _____ _____

	Yes	No
Have you ever had an adverse reaction (nausea, dizziness) with any drug or medication?	o	o
Do you have any disease, condition or medical problem not listed you feel we should know about?	o	o

If you *currently* take these medications, check the box on the left and list the name of medication. If you have taken any of these medications within the <u>past year</u>, but are not taking them currently, check the box on the right.

o Antibiotics _____	o
o Antidepressants (such as Prozac, Zoloft, etc.) _____	o
o Antihistamines _____	o
o Blood pressure medication _____	o
o Blood thinners _____	o
o Cortisone (Prednisone)	o
o Cholesterol medication _____	o
o Decongestants _____	o
o Diuretics (water pills) _____	o
o Hormones (birth control, estrogen)	o
o Inhalants _____	o
o Insulin _____	o
o Heart medication/nitroglycerine _____	o
o Muscle relaxants _____	o
o Pain medication (Aspirin, Advil, Tylenol) _____	o
o Sleeping pills _____	o
o Thyroid medication _____	o
o Tranquilizers _____	o
o Vitamins _____	o
o Others _____ _____	o

PATIENT SIGNATURE

_____

Date: _____