Name: ____ Date of Birth: _______________________

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.

Have you had any of the following diseases or problems?	**YES**	**NO**
Active tuberculosis	☐	☐
Persistent cough greater than 3 week duration	☐	☐
Cough that produces blood	☐	☐

	YES	**NO**
1. Are you in good health?	☐	☐
2. Has there been any change in your general health within the past year?	☐	☐
3. Are you now under the care of a physician?	☐	☐

If yes, what is/are the condition(s) being treated:

____

____

____

____

4. Date of last physical examination:

____

Physician's Name(s):

____

____

____

____

	YES	**NO**
5. Have you had any serious illness, operation, or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem?

____

____

____

____

6. Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	YES	**NO**
Abnormal bleeding	☐	☐
AIDS of HIV Infection	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Blood transfusion	☐	☐
If yes, date of transfusion: ______________________		
Cancer, chemotherapy/radiation treatment	☐	☐
Cardiovascular disease	☐	☐

If yes, specify below:

- ☐ Artificial heart valves
- ☐ Congenital heart defect
- ☐ Coronary artery disease
- ☐ Damaged heart valves
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic fever/ Rheumatic heart disease

	YES	**NO**
Diabetes	☐	☐
Disease, drug or radiation induced immunosuppression	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Hemophilia	☐	☐
Hepatitis	☐	☐
Liver disease	☐	☐
Kidney problems	☐	☐
Osteoporosis	☐	☐
Respiratory problems	☐	☐
☐ Emphysema ☐ Bronchitis		
Severe headaches/migraines	☐	☐
Sinus trouble	☐	☐
Stroke	☐	☐
Systemic lupus erythematosus	☐	☐
Thyroid problems	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Do you have any disease, condition, or problems not listed above that you think I should know about?	☐	☐

____

____

ADULT MEDICAL HISTORY (13 YEARS AND ABOVE)

	YES	NO
7. Are you taking, or have you taken, any diet drugs such as Pondimin® (fenfluramine), Redux® (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐
8. Are you taking, or scheduled to begin taking any of the medications, alendronate (Fosomax®), risedronate (Actonel®) or ibandronate (Boniva®), for osteoporosis or Paget's disease?	☐	☐
9. Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia®, Bonefos® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myleoma or metastatic cancer?	☐	☐

Date treatment began: ______________________

PLEASE LIST ALL CURRENT MEDICATIONS HERE:

____

____

____

10. Are you ALLERGIC to or have you had a reaction to:

	YES	NO
Local anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐
Sulfa drugs	☐	☐
Iodine	☐	☐
Other	☐	☐

If yes, explain: _________________________

____

	YES	NO
11. Have you ever had any allergic reaction to any latex products (balloons, surgical gloves, surgical tubing, etc.)	☐	☐
12. Do you smoke?	☐	☐

If yes: ☐ Daily ☐ Socially

	YES	NO
13. Do you use smokeless tobacco?	☐	☐
14. Do you drink alcoholic beverages?	☐	☐

If yes: ☐ Daily ☐ Socially

	YES	NO
15. Do you use drugs or other substances for recreational purposes?	☐	☐

If yes, please list:

____

	YES	NO
16. Are you alcohol and/or drug dependent?	☐	☐
If yes, have you received treatment?	☐	☐
17. Have you had any unexplained or unplanned weight loss recently?	☐	☐
18. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐

If yes, when was this operation done?

____

	YES	NO
19. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐

WOMEN ONLY

	YES	NO
20. Are you currently pregnant?	☐	☐

Expected delivery date: ____________________

	YES	NO
21. Nursing?	☐	☐
22. Taking birth control pills or hormonal replacement?	☐	☐

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

____

Signature of Patient/Legal Guardian Date

____

Doctor's Initials

BP:

Pulse:

Notes: