Name:______________________________ Date:_____/_____/_____

Do you have, **or have you ever had**, any of the following:

1. Cardiovascular/Heart Problems: ______________________ Yes No

   Any heart surgeries:______________________ Yes No

2. Artificial Joints (If yes, which joints and when):______________________ Yes No

____

3. Pacemaker: ______________________ Yes No

4. High or Low Blood Pressure:______________________ Yes No

5. Back Problems:______________________ Yes No

6. Bleeding Disorder: ______________________ Yes No

7. Cancer (If yes, please specify):______________________ Yes No

8. Stroke: ______________________ Yes No

9. Diabetes: ______________________ Yes No

10. Sleep Apnea:______________________ Yes No

11. Hepatitis (If yes, what kind): ______________________ Yes No

12. Do you wear any oral appliances: ______________________ Yes No

13. HIV / AIDS:______________________ Yes No

14. Herpes Simplex/cold sores: ______________________ Yes No

15. Acid Reflux/Gerd:______________________ Yes No

16. Seizures or fainting spells:______________________ Yes No

17. Are you allergic or have you had a reaction to: (please circle)

    Local Anesthetics Penicillin(or other antibiotics) Sulfa Drugs

    Aspirin Iodine

    Other medication allergies:______________________

18. Have you ever taken any osteoporosis medication:______________________ Yes No

19. Food or seasonal allergies:______________________ Yes No

20. Do you or have you ever smoked (How much per week):______________________ Yes No

OVER ➡

Name:____ Date:______/______/______

21. Do you drink alcohol (How much per week): ________________________________ Yes No

22. Drug Dependency:____ Yes No

23. Psychiatric care: ____ Yes No

24. Tuberculosis:____ Yes No

25. Arthritis:____ Yes No

26. Do you have any disease or condition not listed above that you think I should

know about:____ Yes No

Women: Are you currently pregnant or nursing:__________ _______________________ Yes No

Are you currently taking birth control pills:_____________________________ Yes No

Chief Dental Complaint: ____

Please list all medications and/or supplements you are currently taking:

Medication Name	Dosage

Please describe any recent medical treatment, impending operations or any other medical/dental information:

____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____ _______________________________

(Signature of patient or guardian) (Date)