

Name: _____

All information is held in the strictest confidence

1. How would you estimate your general health? POOR FAIR GOOD EXCELLENT
2. Have you been hospitalized in the past two years? yes no
If yes please explain: _____
3. Are you currently under the care of a physician? yes no
Reason? _____ Date of last visit? _____
Physician's name _____ Phone number: _____
4. Are you currently taking any prescribed medications, drugs or pills? yes no
If yes please list name and dose: _____
5. Are you regularly taking any other drugs, over-the-counter medications, or supplements yes no
If yes please list name and dose: _____
6. Do you smoke or use any tobacco products? yes, currently smoke no, but did in the past never
7. Have you needed to take antibiotic premedication prior to dental treatment? yes no
8. Are you now or have you ever taken oral bisphosphonate ie. Fosamax, Actonel or Boniva yes no
9. **The following conditions may indicate a need to take antibiotics prior to dental treatment. This is to prevent systemic infections like bacterial endocarditis - a potentially fatal condition. Please mark any of the following, which you have had or have at present.**

- | | | | |
|-------------------------------------------------|---------------------------------------------|-----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Use of FenPhen/Redux | <input type="checkbox"/> <u>NONE APPLY</u> |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Plastic Surgery or | <input type="checkbox"/> Placement of stents or any | |
| <input type="checkbox"/> Heart Murmur | Implantation | other prosthetic/implant | |
| <input type="checkbox"/> Heart Valve Problem | <input type="checkbox"/> Rheumatic Fever | | |

DO YOU CURRENTLY HAVE OR HAVE YOU EVER EXPERIENCED THE FOLLOWING:

Check any of the following that apply:

- | | | |
|----------------------------------------------|--------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies/Hives | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Head/Neck Injury | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cold Sores / Herpes | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | |

DO YOU HAVE OR HAVE YOU EVER HAD AN ALLERGY OR ADVERSE REACTION TO:

Check any of the following that apply:

- | | |
|-------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Local anesthetics ("Novocaine") | <input type="checkbox"/> Codeine, Demerol, other narcotics |
| <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Reaction to metals |
| <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Latex or rubber dam |
| <input type="checkbox"/> Barbiturates or Sedatives | <input type="checkbox"/> Other |
| <input type="checkbox"/> Aspirin, Acetaminophen, Ibuprophen | _____ |

WOMEN: Are you taking contraceptives yes no Are you pregnant? yes, due _____ no

PLEASE PROVIDE ADDITIONAL INFORMATION ABOUT ANY CHECKED ITEMS

I certify that the above information is correct to the best of my knowledge. I agree to keep this office informed of any changes in my health or any medications I may be taking.

X Signed: _____ Date: _____