For Office Use Only	Name: ______________________ Last, First M I.	____________ Date of Birth

Please respond to each of the following questions:

☐ Yes ☐ No Are you in good health now?

☐ Yes ☐ No Are you under the care of a physician?
If so, what is the condition being treated? ____________________

☐ Yes ☐ No Have you ever been hospitalized or had a serious illness?
If yes, explain. ____________________

☐ Yes ☐ No Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?

☐ Yes ☐ No (Women) Are you pregnant? If so, what is your due date? ____________

☐ Yes ☐ No (Women) Are you on birth control pills?
(If so, you should use an additional form of birth control while on antibiotics)

Are you allergic to any of the following?

☐ Yes ☐ No Local Anesthetics (e.g., Novocaine)

☐ Yes ☐ No Barbiturates, Seditives/sleeping pills

☐ Yes ☐ No Penicillin

☐ Yes ☐ No Tetracycline

☐ Yes ☐ No Other Allergies? Explain:

____

☐ Yes ☐ No Aspirin

☐ Yes ☐ No Codeine

☐ Yes ☐ No Sulfa Drugs

☐ Yes ☐ No Erythromycin

☐ Yes ☐ No Latex

Are you currently taking:

☐ Yes ☐ No Blood Thinners (ex Coumadin, Warfarin, Pradaxa)

☐ Yes ☐ No Bisphosphonates (ex: Fosamax, Boniva, Reclast, Actone, Zometa)

Do you need to pre-medicate before a dental procedure? If so, explain below:

☐ Yes ☐ No ____________________

____

____

Please list all prescription and non-prescription drugs you are currently taking.

____

____

____

Pharmacy Name. ____________ Location: ____________ Phone: ____________

For Office Use Only	Name: ______________________	______________
	Last, First M I	Date of Birth

Do you currently have (or previously had) any of the following?

☐Yes ☐No Persistent fever
☐Yes ☐No Eruptions (rash) hives
☐Yes ☐No Glaucoma
☐Yes ☐No Loss of hearing
☐Yes ☐No Ringing in ears
☐Yes ☐No Frequent nosebleeds
☐Yes ☐No Sinus problems
☐Yes ☐No Stroke
☐Yes ☐No Convulsions/epilepsy
☐Yes ☐No Dizziness/fainting
☐Yes ☐No Psychiatric treatment
☐Yes ☐No Tuberculosis
☐Yes ☐No Emphysema
☐Yes ☐No Asthma/hay fever
☐Yes ☐No Diabetes
☐Yes ☐No Thyroid condition/goiter
☐Yes ☐No Swelling of ankles
☐Yes ☐No Hepatitis
☐Yes ☐No Jaundice
☐Yes ☐No Kidney disease
☐Yes ☐No Shortness of breath
☐Yes ☐No Drug/alcohol addiction
☐Yes ☐No Rheumatic fever
☐Yes ☐No Heart murmur
☐Yes ☐No Chest pain/discomfort
☐Yes ☐No Heart attack/trouble
☐Yes ☐No High blood pressure
☐Yes ☐No Congenital heart disease
☐Yes ☐No Mitral valve prolapse
☐Yes ☐No Artificial heart valve
☐Yes ☐No Pacemaker
☐Yes ☐No Heart surgery
☐Yes ☐No Taking anticoagulants
☐Yes ☐No Other heart problems
☐Yes ☐No Arthritis/rheumatism
☐Yes ☐No Artificial joints
☐Yes ☐No Implant/graft surgery
☐Yes ☐No Venereal disease
☐Yes ☐No Bruise easily
☐Yes ☐No Blood transfusion
☐Yes ☐No Radiation therapy
☐Yes ☐No Tumors or growths
☐Yes ☐No Cancer
☐Yes ☐No AIDS/HIV+

Is there any disease, condition, or problem not listed above that you think we should know about or is there any activity your doctor says you cannot do? If so, please explain:

____

____

____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

In case of emergency, contact: ______________________ Phone: ______________

Signature of patient, parent, or guardian: ______________________ Date: ______________

Doctor's signature: ______________________ Date: ______________