Name:_____ Date:_____

Name of Physician/and their specialty:_____

Most recent physical examination: _____Purpose: _____Recent Height: _____ Weight: _____

What is your estimate of your general health? □ Excellent □ Good □ Fair □ Poor

Do you need an Antibiotic Pre-Medications for dental treatment? □Yes Please list: _____ □No

Do you receive pain medication from your primary physician? □Yes □No If yes what:_____

How often:_____ Prescriber:_____

Failure to inform us of medication can result in us denying prescriptions.

An allergic Reaction to:

□ Aspirin □ Penicillin □ Erythromycin □Tetracycline
□ Sulfa □ Local Anesthetic □ Fluoride □ Metals (Nickel, Gold, Silver, _____)
□ Latex □ Ibuprofen □ Acetaminophen □ Codeine

Do you have or have you ever had Y-Yes, N-NO:

□ Y □ N Hospitalizations for illness or injury
□ Y □ N Anemia or other blood disorder
□ Y □ N Thyroid, parathyroid disease, or calcium deficiency
□ Y □ N Contact lenses
□ Y □ N HIV/AIDS
□ Y □ N Heart problems, or cardiac stent within the last six months
□ Y □ N Prolonged bleeding due to a slight cut (INR>3.5)
□ Y □ N Hormone Deficiency
□ Y □ N Head or neck injuries
□ Y □ N Tumor, abnormal growth
□ Y □ N History of infective endocarditis
□ Y □ N Emphysema, Sarcoidosis
□ Y □ N High cholesterol or taking statin drugs
□ Y □ N Epilepsy, convulsions (seizures)
□ Y □ N Radiation therapy
□ Y □ N Artificial heart valve, repaired heart defect (PFO)
□ Y □ N Tuberculosis
□ Y □ N Diabetes (HbA1c=_____)
□ Y □ N Neurologic problems (attention deficit disorder)
□ Y □ N Chemotherapy
□ Y □ N Pacemaker or implantable defibrillator
□ Y □ N Asthma
□ Y □ N Stomach or duodenal ulcer
□ Y □ N Viral infections and cold sores
□ Y □ N Emotional problems
□ Y □ N Artificial prosthesis (heart valve or joints)
□ Y □ N Breathing or sleep problems (i.e. snoring)
□ Y □ N Digestive disorders (i.e. gastric reflux)
□ Y □ N Any lumps or swelling in the mouth
□ Y □ N Psychiatric treatment
□ Y □ N Rheumatic or scarlet fever
□ Y □ N Kidney Disease
□ Y □ N Osteoporosis/osteopenia (i.e. taking bisphosphonates)
□ Y □ N Hives, skin rash, hay fever
□ Y □ N Antidepressant Medication
□ Y □ N High or low blood pressure
□ Y □ N Liver Disease
□ Y □ N Arthritis
□ Y □ N STI/STD
□ Y □ N Alcohol/street drug use
□ Y □ N Stroke (taking blood thinners)
□ Y □ N Jaundice
□ Y □ N Glaucoma
□ Y □ N Hepatitis (Type_____)

Other:_____

Are you:

□ Presently being treated for any other illness
□ Taking dietary supplements
□ A smoker, smoked previously or use smokeless tobacco
□ FEMALE- Taking birth control
□ Aware of a change in your health (i.e. fever, new cough)
□ Often exhausted or fatigued
□ Considered a touchy person
□ FEMALE- Pregnant
□ Taking medication for weight management (i.e. fen-phen)
□ Experiencing frequent headaches
□ Often unhappy or depressed
□ MALE- Prostate Disorder

Describe any current treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment._____

_____

List all medications, supplements, and or vitamins taken within the last two years and their purpose (Or bring list in):_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

_____ _____

Patient, Parent or Guardian: Signature of Doctor