

Pharmacy Name: _____ Phone Number: _____

Physician's name? _____

Have you ever been told you need to **Antibiotic Premedicate** prior to dental appointment? Yes No If yes _____

Have you been hospitalized or had a major operation in the last 5 years? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications Rx or over the counter? Yes No If yes _____

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Do you take blood thinners? Yes No If yes _____

Are you on a special diet? Yes No If yes _____

Do you use tobacco? Yes No If yes _____

Do you use controlled substances? Yes No If yes _____

Women: Are you... Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? Asprin Penicillin Codeine Acrylic Metal Latex
 Sulfa Drugs Local Anesthetics Other None _____

Do you have or have you had, any of the following?

- | | | | | | | | |
|---------------------------|----------------------------------------------------|---------------------------|----------------------------------------------------|-----------------------|----------------------------------------------------|----------------------------|----------------------------------------------------|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Joint Replacement | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problems | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Mumur | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |

Any other health concerns or issues not listed? _____

**NEW PATIENTS
DENTAL HISTORY**

Previous Dentist _____

Date of last dental exam: _____ Date of last dental x-rays _____

Has the patient had any injuries to the face, mouth, or teeth? Yes No Describe _____ Have you had problems associated with previous dental treatments? Yes No

Do your gums bleed when you brush or floss? Yes No Is your home water fluoridated? Yes No

Are your teeth sensitive to cold, hot, sweets, or pressure? Yes No Are you currently experiencing dental pain or discomfort? Yes No

Does food or floss catch between your teeth? Yes No Do you have clicking, popping or discomfort in the jaw? Yes No

Is your mouth dry? Yes No Do you clench or grind your teeth? Yes No

Have you ever had perio (gum) treatments? Yes No Do you have sores or ulcers in your mouth? Yes No

Have you ever had ortho (braces) treatments? Yes No Do you wear dentures or partials? Yes No

Reviewed:

Initial/Date Initial/Date Initial/Date Initial/Date Initial/Date