

Patient's Health History

Allergies:

- Aspirin Latex Penicillin or other antibiotics Sulfa drugs
 Local anesthetics Codeine None Other: _____

Please check any of the following conditions you currently have or have had:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hypotension | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Stroke / (TIA) | <input type="checkbox"/> Implanted device | <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Artificial valves |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Valve Prolapse | <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Shingles | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Herpes | <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Diabetes T1 or T2 |
| <input type="checkbox"/> Auto-immunity | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Cancer / Tumor | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Fainting / Dizzy | <input type="checkbox"/> Seizures | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> GI disorders | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Other: _____ | | | | |

Explanation for any above selected conditions: _____

List any recent surgeries: _____

Women Only: Pregnant / Trying Nursing Oral contraceptives

Habits & Frequency: Tobacco _____ Smoke _____ Vaping _____

Alcohol _____ Recreational Drugs: _____

Are you, or have you ever taken, *bone density meds*, or Bisphosphonates such as Alendronate (Fosamax), ibandronate (Bonvia), Risedronate (Actonel), Zoledronic acid (Reclast), Prolia (Denosumab), or Bevacizumab (Avastin) YES NO

Are you currently taking any blood thinners such as (coumadin, Plavix, Aspirin, Vitamin E, Fish Oil, Pradaxa, Aggrenox) YES NO

Have you ever been hospitalized for or received operation for any head and neck injury YES NO

Do you use controlled substances YES NO

List all medications / vitamins you are currently taking (prescription or OTC): _____



Patient's Dental History

Chief Dental Concern: _____

Check any of the following that apply:

- Pain Sensitivity Swelling Bleeding gums Jaw pain TMJ issues
 Bad breath Mobile teeth Gag Reflex Difficulty eating
 Other: _____

Previous Dental Treatments:

- Fillings Crowns / Bridges Root canals Extractions Implants Dentures
 Partial Ortho treatment Gum therapy Deep cleaning
 Other: _____

Oral Hygiene Habits:

- Brush (____X/day) Floss daily Mouthwash Other: _____

Dental Anxiety / Fear: None Mild Moderate Severe

Date of last dental x-rays: ___ / ___ / ___

Date of last dental cleaning: ___ / ___ / ___

Date of last dental exam: ___ / ___ / ___

Consent & Acknowledgment

I certify that the above information is true and complete to the best of my knowledge. I understand that withholding information may put my health at risk. I consent to treatment recommended by my dentist and acknowledge that I may be asked to update this form regularly.

Signature of Patient / Guardian: _____ Date: ___ / ___ / ___

Doctor Signature: _____ Date: ___ / ___ / ___