

**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?

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Local Anesthetics (e.g., Novocaine) | <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Barbiturates, Sedatives/sleeping pills | <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No Sulfa Drugs |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tetracycline | <input type="checkbox"/> Yes <input type="checkbox"/> No Erythromycin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Other Allergies? Explain: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

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

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