Patient's Name ______________________ Date of Birth ______________

Medical Doctor Name ______________________ Phone ______________

**Please answer the following question as completely as possible (circle YES or NO)**

| # | Question | | |
|---|---|---|---|
| 1. | Do you consider yourself to be in good health? | YES | NO |
| 2. | Are you now or have you been under a physician's care within the past year? | YES | NO |
| | If YES, specify condition being treated: | YES | NO |
| 3. | Do you take any medications, including birth control pills? If **YES**, specify name and purpose of medication: | YES | NO |
| 4. | Do you have, or have you ever had any heart or blood problems? | YES | NO |
| 5. | Have you ever been told you have a heart murmur? | YES | NO |
| 6. | Do you require antibiotic pre-medication for a heart condition, artificial valve, or artificial joint? | YES | NO |
| 7. | Do you have, or have you ever had high blood pressure? | YES | NO |
| 8. | Do you bleed or bruise easily? | YES | NO |
| 9. | Have you ever been diagnosed as being HIV positive or having AIDS? | YES | NO |
| 10. | Have you ever had hepatitis or liver disease? | YES | NO |
| 11. | Have you ever had: Rheumatic Fever ☐ Asthma ☐ any Blood Disorder ☐ Diabetes ☐ Rheumatism ☐ Arthritis ☐ Tuberculosis ☐ Venereal Disease ☐ Heart Attack ☐ Kidney Disease ☐ Immune System Disease ☐ Other Disease ☐ | YES | NO |
| 12. | Have you ever had an unusual reaction, or are you allergic to any of the following drugs: Penicillin ☐ Aspirin ☐ Acetaminophen ☐ Ibuprofen ☐ Codeine ☐ Barbiturates ☐ Sulfa Drugs ☐ Other ☐ | YES | NO |
| 13. | Are you subject to fainting? | YES | NO |
| 14. | Have you ever had any severe reaction to dental treatment or local anesthetics? | YES | NO |
| 15. | Are you allergic to any local anesthetics? | YES | NO |
| 16. | Do you have any other allergies? If **YES**, please explain | YES | NO |
| 17. | Have you ever had a nervous breakdown or undergone psychiatric treatment? | YES | NO |
| 18. | Have you ever received counseling for excessive use of alcohol and/or prescription drugs? | YES | NO |
| 19. | Women: Are you pregnant? | YES | NO |
| 20. | Are you now in pain? | YES | NO |
| 21. | How long ago did you last see a dentist? | | |
| 22. | Who was your previous dentist? | | |
| 23. | Do you think that your teeth are affecting your general health in any way? | YES | NO |
| 24. | Do you have or have you ever had bleeding or sensitive gums? | YES | NO |
| 25. | Have you ever taken Phen-Fen or similar appetite suppressants? | YES | NO |
| | If **YES**, have you seen your physician or cardiologist for a cardiac evaluation? | YES | NO |

## DENTAL INFORMATION

| | | |
|---|---|---|
| YES | NO | Do you have any pain in or near your ears? |
| YES | NO | Do you habitually clench your teeth during the day or night? |
| YES | NO | Are any areas of your mouth sore or sensitive to sweets, hot, cold, or chewing problems? |
| YES | NO | Any reactions or allergic symptoms to novocaine or xylocaine? |
| YES | NO | Any difficult extractions? Any prolonged bleeding following extractions? |
| YES | NO | Do you have or have you had bleeding gums? |
| YES | NO | Have you ever been instructed in caring for your gums? |
| YES | NO | Have you ever been instructed in the prevention of decay? |
| YES | NO | Have you ever had a series of full x-rays in the past year? |
| YES | NO | Do you have any present dental complaints? |