Patient Name:_____ Date of Birth (Month/Day/Year) _____

Please answer all of the following questions by circling YES or NO. Your responses will be held strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concern to a member of our team.

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

Angina (chest pain)	Yes	No	FOR OFFICE USE ONLY
Arthritis (Osteo or Rheumatoid)	Yes	No	
Artificial joints (Hip / Knee / Ankle / Shoulder / Other _____	Yes	No	
Asthma	Yes	No	
Bleeding problem / Anemia / Other blood disease	Yes	No	
Cancer	Yes	No	
Congenital heart defect/disease	Yes	No	
Congestive heart failure	Yes	No	
Diabetes	Yes	No	
Fainting/Seizures/Nervous system disease (Epilepsy/Convulsions)	Yes	No	
Glaucoma	Yes	No	
Hearing impairment	Yes	No	
Heart attack or heart disease	Yes	No	
Heart murmur or mitral valve prolapse	Yes	No	
Heart valve replacement	Yes	No	
Hepatitis (A, B, C or other)	Yes	No	
High blood pressure	Yes	No	
Immunosuppressive condition (Steroid therapy / Radiation therapy / Chemotherapy / SLE (Lupus) / HIV / Organ transplant / Spleen removal / Other _____	Yes	No	
Irregular heart beat	Yes	No	
Kidney disease	Yes	No	
Mental health condition – Specify _____	Yes	No	
Other artificial implants or devices	Yes	No	
Other liver disease _____	Yes	No	
Other lung disease (Emphysema/COPD) _____	Yes	No	
Other muscle or joint disease _____	Yes	No	
Pacemaker or Defibrillator	Yes	No	
Previous bacterial endocarditis	Yes	No	
Rheumatic fever/Rheumatic heart disease	Yes	No	
Sexually transmitted disease/infection	Yes	No	
Stomach or intestinal disease (Ulcer/GERD)	Yes	No	
Stroke	Yes	No	
Thyroid disease	Yes	No	
Tuberculosis	Yes	No	
Visual impairment	Yes	No	

Do you have any disease, conditions or problems not listed here? Please list			FOR OFFICE USE ONLY
Please list any hospitalizations and surgeries			
Do you have any allergic reactions to medications or latex? Please circle all that apply.	Latex Penicillin or other antibiotics Aspirin Codeine Metal Iodine Local anesthetics such as Lidocaine Others _____		
Have you ever undergone current or past osteoporosis therapy? Taken medications such as Fosamax, Actonel, Boniva?			
Have you ever undergone current or past bisphosphonate therapy? Had intravenous therapy with medications such Aredia, Zometa?			
Are you or could you be pregnant? If yes how many months _____	YES	NO	
Are you breast-feeding?	YES	NO	
Do you take birth control?	YES	NO	
Are you or have you ever been addicted to a chemical substance (alcohol, prescription drugs, heroin, meth, cocaine, other _____?	YES	NO	
Do you smoke or use tobacco products?	If yes – how much do you use per day? _____		
Do you have a parent, sibling or child that has any of the following? (Diabetes / High blood pressure / Heart disease / Bleeding tendency / Cancer)			

Are you currently taking any prescription medications, over the counter (OTC) items or herbal supplements? If so please list.

NAME	DOSAGE	REASON FOR TAKING

DENTAL HISTORY			
Reason for your visit today _____			
Do you have regular dental checkups?	Date of last exam _____		
Have you had any trouble with previous dental treatment?	If yes please explain _____		
Have you noticed any lumps or sores in your mouth?	YES	NO	
Do your gums bleed when you brush your teeth?	YES	NO	
Do you clench or grind your teeth?	YES	NO	
Do you have any pain in the mouth, face, eyes, neck or throat?	YES	NO	
Have you injured your face, jaw or teeth?	YES	NO	
Are you unhappy with the look of your teeth and/or smile?	YES	NO	
Circle any of the following dental procedures you have had Orthodontics(braces) Dentures Root canal treatment Implants Oral surgery Periodontal(gum) treatment Fillings TMJ treatment Crowns Bridges Veneers Bleaching Other _____			
How many times per day do you brush? _____			
How many times per day do you floss? _____			
PLEASE ANSWER THE FOLLOWING FOR ALL CHILDREN			
Do they suck their thumb or fingers?	YES	NO	
Do they suck or bite their lips?	YES	NO	
Do they bite or chew their nails?	YES	NO	
Do they use fluoride toothpaste?	YES	NO	
Do they use any other fluoride products like mouthwash or prescription fluoride?	YES	NO	
Does a parent or adult help with brushing?	YES	NO	
Do they eat sugary foods and/or snacks? – if yes what and how much _____	YES	NO	
Do they drink anything besides water or milk? – if yes what and how much _____	YES	NO	
PLEASE ANSWER THE FOLLOWING FOR CHILDREN AGES 0 – 5 YEARS OLD			
Is the child breast or bottle fed?	YES	NO	
Age in months that child was weaned _____			
Is or was the child given a bottle or Sippy-cup to suck on to fall asleep	YES	NO	

To the best of my knowledge all the preceding information is correct and complete. If I have any changes in my health status, or any changes in medication, I will inform the dental health provider at my next appointment. I am responsible for any errors or omissions of information. I consent to all examinations including exams, x-rays and other tests that may be necessary in the judgment of the provider for diagnostic purposes.

Patient / Guardian Signature _____

Date _____

Dentist Signature _____

Date _____