PATIENT NAME: _____

List your MEDICATIONS/DOSE/CORRELATING DIAGNOSIS

INCLUDE NATURAL HERBS AND VITAMINS

_____

_____

_____

_____

_____

DO YOU TAKE BLOOD THINNING MEDICATION? YES or NO (circle please)_____
Drug name

ARE YOU PREGNANT? _____ DUE DATE:_____OBGYN:_____

ALLERGIES: CHECK ALL THAT APPLY

- ❑ ASPIRIN
- ❑ LATEX
- ❑ SLEEPING PILLS
- ❑ CODEINE
- ❑ IODINE
- ❑ LOCAL ANESTHETIC
- ❑ PENICILLIN
- ❑ IBUPROFEN
- ❑ METALS (gold, iron, tin, nickel, zinc, silver)
- ❑ PAIN RELIEVERS_____
- ❑ SULFA (antibiotics)
- ❑ OTHER: _____

Primary Care Physician: _____ Phone Number: _____
Date of last visit:_____

Specialist Physician: _____ Phone Number: _____
Date of last visit:_____

PLEASE MARK ANY CONDITIONS THAT WOULD APPLY TO PATIENT:

If you have a condition not listed, please list in the area marked OTHER.

- ❑ DOES PATIENT NEED TO BE PREMEDICATED BEFORE DENTAL APPOINTMENT
- ❑ AIDS/HIV
- ❑ ALCOHOLISM
- ❑ ANEMIA
- ❑ ARTHRITIS, RHEUMATISM
- ❑ ARTIFICIAL HEART VALVES
- ❑ ARTIFICIAL JOINTS
- ❑ ASTHMA
- ❑ BACK PROBLEMS
- ❑ BLEEDING ABNORMALLY WITH EXTRACTIONS OR SURGERY
- ❑ BLOOD DISEASE/BLOOD CLOTS
- ❑ CANCER
- ❑ CHEMOTHERAPY
- ❑ CHOLESTEROL
- ❑ CROHNS DISEASE
- ❑ CIRCULATORY PROBLEMS
- ❑ CORTISONE TREATMENTS
- ❑ COUGH, PERSISTENT OR BLOODY
- ❑ DEPRESSION
- ❑ DIABETES
- ❑ EMPHYSEMA
- ❑ EPILEPSY
- ❑ FAINTING OR DIZZINESS
- ❑ GLAUCOMA
- ❑ HEADACHES
- ❑ HEART MURMUR
- ❑ HEART PROBLEMS_____
- ❑ HEPATITIS TYPE_____
- ❑ HERPES
- ❑ HIGH BLOOD PRESSURE
- ❑ JAUNDICE
- ❑ JAW PAIN
- ❑ KIDNEY DISEASE
- ❑ LIVER DISEASE
- ❑ LOW BLOOD PRESSURE
- ❑ MITRAL VALVE PROLAPSE
- ❑ MULTIPLE SCLEROSIS
- ❑ MUSCULAR DYSTROPHY
- ❑ NERVOUS PROBLEMS
- ❑ PACEMAKER
- ❑ PARKINSON'S DISEASE
- ❑ PSYCHIATRIC CARE
- ❑ RADIATION TREATMENT
- ❑ RESPIRATORY DISEASE
- ❑ RHEUMATIC FEVER
- ❑ SCARLET FEVER
- ❑ SEIZURES/CONVULSIONS
- ❑ SHORTNESS OF BREATH
- ❑ SINUS TROUBLE
- ❑ SKIN RASH
- ❑ SLEEP APNEA
- ❑ SPECIAL DIET
- ❑ STROKE
- ❑ SWOLLEN FEET OR ANKLES
- ❑ SWOLLEN NECK GLANDS
- ❑ THYROID PROBLEMS
- ❑ TONSILITIS
- ❑ TUBERCULOSIS
- ❑ TUMOR OR GROWTH ON HEAD OR NECK
- ❑ ULCERS
- ❑ VENEREAL DISEASES (STD's)
- ❑ WEIGHT LOSS, unexplained
- ❑ OTHER_____

_____

_____

_____

APATIENT SIGNATURE: _____ DATE: _____
(OR ADULT/GUARDIAN IF MINOR)

DENTAL HISTORY

Reason for today's visit? _____

Former Dentist:_____ City: _____ State:_____

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

How often do you floss? _____ How often do you brush? _____

Do you use tobacco products? Y or N Type: _____ How often: _____
Circle

PLEASE INDICATE IF YOU HAVE HAD ONE OF THE FOLLOWING:

- ❑ **BAD BREATH**
- ❑ **BLEEDING GUMS**
- ❑ **BURNING SENSATION ON TONGUE**
- ❑ **BLISTERS ON LIPS OR MOUTH**
- ❑ **CHEW ON ONE SIDE OF MOUTH**
- ❑ **CLICKING OR POPPING IN JAW**
- ❑ **DRY MOUTH**
- ❑ **FINGERNAIL BITING**
- ❑ **FOOD COLLECTION BETWEEN TEETH**
- ❑ **GRINDING TEETH**
- ❑ **GUMS SWOLLEN/TENDER**
- ❑ **JAW PAIN OR FATIGUE**
- ❑ **LIP OR CHEEK BITING**
- ❑ **LOOSE TEETH OR BROKEN FILLINGS**
- ❑ **MOUTH BREATHING**
- ❑ **MOUTH PAIN w/BRUSHING**
- ❑ **ORAL APPLIANCE**
  Type: _____
- ❑ **ORTHONDONTIC TREATMENT**
- ❑ **PAIN AROUND EAR**
- ❑ **PERIODONTAL TREATMENT**
- ❑ **SENSITIVITY TO COLD OR HOT**
- ❑ **SENSITIVITY TO SWEETS**
- ❑ **SENSITIVITY WHEN BITING**
- ❑ **SORES OR GROWTH IN MOUTH**

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine) Pondimin (fenfluramin) and Redux (dexfenfluramine.)
□ Yes □ No

Have you ever been diagnosed as having a chemical dependency or feel that you are chemically dependant?
□Yes □ No If so, how long have you been in recovery? _____

Have you had any of these drugs in the last 24 hours?
□ Cocaine □ Ecstacy □ Methamphetamine

IN CASE OF EMERGENCY, CONTACT:

Name:_____Relationship:_____

Home Phone:_____ Work Phone:_____ Cellular:_____