



Patients Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Physician \_\_\_\_\_ Name of Clinic/Phone \_\_\_\_\_/(\_\_\_\_\_) \_\_\_\_\_ Last visit \_\_\_\_\_

**5 HEALTH HISTORY – Have you had any of the following medical conditions? Please check “Yes” or “No”**

**1. CARDIOVASCULAR**

- Heart Disease or attack  Yes  No
- Angina pectoris/chest pain  Yes  No
- High blood pressure  Yes  No
- Congenital heart defect or lesion  Yes  No
- Artificial heart valve  Yes  No
- Heart pacemaker  Yes  No
- Heart Surgery or transplant  Yes  No
- Other heart problems  Yes  No
- Stroke/Aneurysm  Yes  No

**2. HEMATOLOGIC**

- Anemia  Yes  No
- Hemophilia  Yes  No
- Leukemia  Yes  No
- Sickle cell (anemia) disease  Yes  No
- Bleed longer than normal  Yes  No

**3. NEURAL AND SENSORY**

- Glaucoma  Yes  No
- Psychiatric treatment  Yes  No
- Fainting and dizzy spells  Yes  No
- Epilepsy, seizures or convulsions  Yes  No
- Down’s syndrome  Yes  No
- Cognitive disorder  Yes  No
- Autism Spectrum Disorder  Yes  No

**4. GASTROINTESTINAL**

- Colitis/Ulcers  Yes  No
- Crohn’s disease  Yes  No
- Eating disorder  Yes  No
- Hepatitis - Type \_\_\_\_\_  Yes  No
- Liver disease  Yes  No
- GERD (gastric reflux)  Yes  No

**5. RESPIRATORY**

- Sinus trouble  Yes  No
- Asthma  Yes  No
- Emphysema  Yes  No
- Tuberculosis  Yes  No

**6. DERMAL MUCOCUTANEOUS**

- MUSCULOSKELETAL**
- Arthritis  Yes  No
- Artificial joint  Yes  No
- Osteoporosis  Yes  No
- Anti-resorptive therapy (Boniva, Fosamax, Prolia, etc.)  Yes  No
- Cold sore  Yes  No
- Canker sore  Yes  No
- Colored or discolored areas in mouth  Yes  No

**7. ENDOCRINE**

- Diabetes - Type \_\_\_\_\_  Yes  No

**8. URINARY - SEXUALLY TRANSMITTED**

- Dialysis/transplant  Yes  No
- STD  Yes  No
- HIV positive (AIDS)  Yes  No

**9. OTHER CONDITIONS**

- Drug or alcohol addiction (recovering or current)  Yes  No
- Tumor or cancer  Yes  No
- Radiation therapy  Yes  No
- Chemotherapy  Yes  No
- Take Antibiotics prior to Dental appointments  Yes  No
- Disease, problem or condition not listed  Yes  No
- If yes, list \_\_\_\_\_

**10. ARE YOU**

- Taking medications now or Within the past year such as
- Blood thinners  Yes  No
- Cortisone  Yes  No
- Nitroglycerine  Yes  No

**Do you currently smoke or use the following tobacco products?**

- Cigarettes \_\_\_\_\_ Packs/Day?  Vape  Cigar  Chew  None

Have you used tobacco products in the past?  Yes  No How long ago? \_\_\_\_\_

Have you had any serious illness, hospitalization or accident?  Yes  No

If yes, please explain \_\_\_\_\_

**WOMEN:**

- Are you pregnant  Yes  No Due Date \_\_\_\_\_
- Taking birth control pills?  Yes  No
- Are you nursing?  Yes  No

MEDICATIONS	DRUG ALLERGIES
List any medications you are currently taking: _____ _____ _____	<input type="checkbox"/> Codeine <input type="checkbox"/> Other: _____
Pharmacy Name _____ Phone (_____) _____	<input type="checkbox"/> Latex _____
	<input type="checkbox"/> Local Anesthetic _____
	<input type="checkbox"/> Penicillin <input type="checkbox"/> No known allergies

**COMMENTS**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient or Guardian’s Signature \_\_\_\_\_ Date \_\_\_\_\_

**6 UPDATES (to be filled in at future appointments)**

- Yes  No 1. Have there been any changes in your health since your last update?
- Yes  No 2. Have you had any surgeries or been hospitalized within the last year?
- Yes  No 3. Have there been any changes or additions to your medications?
- Yes  No 4. Have you developed any new allergies to medications or other materials?
- Yes  No 5. Are you taking blood thinners?
- Yes  No 6. Are you currently using tobacco products?
- Yes  No 7. Are you pregnant?

Comments for any of the "Yes" answers:

Patient or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Patient or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

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