|  |
| --- |
| Patient Name: |
| Date of Birth: | Height: | Weight: |
| Primary Care Physician: | Phone: | Date of Last Visit: |
| Emergency Contact: | Phone:  | Relationship: |

**Please check Yes or NO for the following questions. Do you have any allergies? \_\_\_\_\_ Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Yes | No | Is a physician currently treating you? | Yes | No | Do you take Aspirin daily? |
| Yes | No | Are you taking any medications now? | Yes | No | Are you on Blood thinners? |
| Yes | No | List all current medications below | Yes | No | Have you been told by a physician that you have a heart murmur |
| Yes | No | Has your health changed in the last year? | Yes | No | Do you often feel exhausted or fatigued? |
| Yes | No | Have you lost weight without dieting in the recent months? | Yes | No | Have you ever had any unusual reactions to dental anesthetic?  |
| Yes | No | Have you ever been seriously Ill or hospitalized? | Yes | No | Would you consider yourself holistic in your approach to health? |
| Yes | No | Do you have any artificial joints/prosthesis? | Yes | No | Do you have a tendency to faint? |
| Yes | No | Have you ever had surgery? | Yes | No | Do you have frequent headaches?  |
| Yes | No | Have you ever had, received treatment for, or been suspected of having cancer? | Yes | No | Do you smoke or use smokeless tobacco? |
| Yes |  No | Are you at high risk for AIDS? | Yes  | No | Any other condition or disease not mentioned? |
| Yes | No | Do you bleed for a long time when you have a cut?  | Yes | No | Would you like to speak to a dentist privately about any problem? |
|  |  | **Women:** |  |  |  |
| Yes | No | Are you pregnant or suspect you may be at this time? | Yes | No | Are you in or past menopause? |

**Have you ever been diagnosed or treated for these conditions? Please check Yes or No.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Yes | No | Jaundice | Yes | No | Anemia |
| Yes | No | Glaucoma | Yes | No | Hives or Skin Rash |
| Yes | No | Rheumatic Fever | Yes | No | Ulcers |
| Yes | No | Hepatitis | Yes | No | Epilepsy/Convulsions |
| Yes | No | Diabetes | Yes | No | Stroke |
| Yes | No | Asthma | Yes | No | Blood disorders |
| Yes | No | Venereal Disease | Yes | No | Sinus Problems |
| Yes | No | Heart Problems | Yes | No | Kidney Problems |
| Yes | No | Chest pains | Yes | No | Radiation Therapy |
| Yes | No | Thyroid Problems | Yes | No | Drug Dependency (Alcohol etc.) |
| Yes | No | Pacemaker | Yes | No | Psychiatric Treatment |
| Yes | No | Tuberculosis | Yes | No | Obstructive Sleep Apnea |
| Yes | No | Acid reflux/GERD |  |  |  |

To the best of my knowledge, all of the preceding information is complete and my answers are true and correct. If I ever have a change in my health, or if my medication changes, I will inform the dentist at the next appointment

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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