

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Do you use tobacco? Yes No If yes

Do you have an artificial joint? Yes No If yes

Do you have an artificial heart valve? Yes No If yes

Have you ever had a heart attack? Yes No If yes

Have you ever had a stroke? Yes No If yes

Have you ever been diagnosed with Sleep Apnea? Yes No If yes

Do you use controlled substances? Yes No If yes

Do you take a blood thinner? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics
- Mint

Other? If yes

Women: Are you...

- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

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

- | | | | |
|---|--|--|---|
| <ul style="list-style-type: none"> AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No Drug Addiction <input type="radio"/> Yes <input type="radio"/> No Easily Winded <input type="radio"/> Yes <input type="radio"/> No High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No Kidney Problems <input type="radio"/> Yes <input type="radio"/> No Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No Cancer <input type="radio"/> Yes <input type="radio"/> No Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No Heart Murmur <input type="radio"/> Yes <input type="radio"/> No Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | <ul style="list-style-type: none"> Corticosteroid Medicine <input type="radio"/> Yes <input type="radio"/> No Diabetes <input type="radio"/> Yes <input type="radio"/> No Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No Leukemia <input type="radio"/> Yes <input type="radio"/> No Liver Disease <input type="radio"/> Yes <input type="radio"/> No Glaucoma <input type="radio"/> Yes <input type="radio"/> No Chest Pains <input type="radio"/> Yes <input type="radio"/> No Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No Bi-Polar <input type="radio"/> Yes <input type="radio"/> No | <ul style="list-style-type: none"> Hemophilia <input type="radio"/> Yes <input type="radio"/> No Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No Angina <input type="radio"/> Yes <input type="radio"/> No Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No Bruise Easily <input type="radio"/> Yes <input type="radio"/> No Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No Osteoporosis <input type="radio"/> Yes <input type="radio"/> No Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No Convulsions <input type="radio"/> Yes <input type="radio"/> No Autism <input type="radio"/> Yes <input type="radio"/> No | <ul style="list-style-type: none"> Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No Anemia <input type="radio"/> Yes <input type="radio"/> No Emphysema <input type="radio"/> Yes <input type="radio"/> No High Cholesterol <input type="radio"/> Yes <input type="radio"/> No Asthma <input type="radio"/> Yes <input type="radio"/> No Blood Disease <input type="radio"/> Yes <input type="radio"/> No Breathing Problems <input type="radio"/> Yes <input type="radio"/> No Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No Chemotherapy <input type="radio"/> Yes <input type="radio"/> No Tuberculosis <input type="radio"/> Yes <input type="radio"/> No Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No Snoring <input type="radio"/> Yes <input type="radio"/> No |
|---|--|--|---|

Have you ever had any serious illness not listed above? Yes No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

ASA CLASSIFICATION (OFFICE USE ONLY)

- ASA I
- ASA II
- ASA III
- ASA IV