## ALLERGIES

| | | |
|---|---|---|
| ☐ **No Know allergies** | ☐ Anesthetic | ☐ Sulfa |
| ☐ Aspirin | ☐ Ibuprofen | ☐ Household Bleach |
| ☐ Codeine | ☐ Clindamycin | ☐ Iodine |
| ☐ Latex | ☐ Erythromycin | ☐ Mouth Rinse |
| ☐ Penicillin | ☐ Tetracycline | ☐ Other |

## MEDICATIONS

**List all medications, Vitamins, herbs, supplements, and over-the-counter medications you are currently taking:**

______________________________________________________________________________

__________________________________________________________________________

**Do you PRE MEDICATE before a dental procedure? If Yes,Why?**______________________________________

**PHYSICANS NAME**________________________________________

**Are you taking any blood thinners? (Asprin, Ibuprofen, Coumadin, Plavix)**______________________________

**Are you taking any bisphosphonates? (Actonel, Boniva, Fosamax, Zometa, Aredia)**______________________

## DENTAL HISTORY

Place a mark "Yes" or "No": to indicate if you have had any of the following:

| | | | |
|---|---|---|---|
| Dry mouth.............................................. | ☐ Yes ☐ No | History of periodontal disease......................... | ☐ Yes ☐ No |
| Grinding teeth....................................... | ☐ Yes ☐ No | Sensitive teeth.................................................. | ☐ Yes ☐ No |
| Gums swollen or bleeding...................... | ☐ Yes ☐ No | Sores or growth in your mouth...................... | ☐ Yes ☐ No |
| Loose teeth or broken fillings.............. | ☐ Yes ☐ No | Cigarette, pipe or cigar smoking.................... | ☐ Yes ☐ No |
| Mouth Breathing.................................... | ☐ Yes ☐ No | Orthodontic treatment.................................... | ☐ Yes ☐ No |

Date Last Dental Exam: PREVIOUS DENTIST Date Last Xrays:

Place a mark "Yes" or "No": to indicate if you have had any of the following:

**Artificial Heart Valves**
☐ Yes ☐ No **Date**______________
**Artificial joints.........** ☐ **Yes** ☐ **No**
Congenital Heart Lesion
☐ Yes ☐ No
Heart Murmur........... ☐ Yes ☐ No
Heart Problems......... ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Low/ Blood Pressure ☐ Yes ☐ No
Mitral Valve Prolapse
☐ Yes ☐ No
Pacemaker................. ☐ Yes ☐ No
Date Placed_________________
Shortness of Breath ☐ Yes ☐ No
**Stroke**...................... ☐ Yes ☐ No
**Stent**......................... ☐ Yes ☐ No
**Date Placed**_________________
AIDS........................... ☐ Yes ☐ No
Anemia..................... ☐ Yes ☐ No
Arthritis..................... ☐ Yes ☐ No
Asthma..................... ☐ Yes ☐ No
Back Problems......... ☐ Yes ☐ No
Hemophillia............ ☐ Yes ☐ No

Blood Disease............... ☐ Yes ☐ No
Blood Transfusion.......... ☐ Yes ☐ No
Cancer.......................... ☐ Yes ☐ No
Cerebral Palsy ............... ☐ Yes ☐ No
Chemotherapy.............. ☐ Yes ☐ No
Circulatory problems... ☐ Yes ☐ No
Cortisone Treatments.... ☐ Yes ☐ No
Cough, persistent.......... ☐ Yes ☐ No
Diabetes...................... ☐ Yes ☐ No
Blood sugar level________________
Drug use....................... ☐ Yes ☐ No
Emphysema................. ☐ Yes ☐ No
Epilepsy........................ ☐ Yes ☐ No
Fainting or dizziness..... ☐ Yes ☐ No
Glaucoma...................... ☐ Yes ☐ No
Headaches.................... ☐ Yes ☐ No
Hepatitis....Type______ ☐ Yes ☐ No
Herpes....................... ☐ Yes ☐ No
HIV Positive.................. ☐ Yes ☐ No
Jaundice........................ ☐ Yes ☐ No
**Please List any conditions or illness not mentioned.**_________________
______________________________

Nervous Problems........... ☐ Yes ☐ No
Psychiatric Care.............. ☐ Yes ☐ No
Radiation Treatment...... ☐ Yes ☐ No
Respiratory Disease......... ☐ Yes ☐ No
Scarlet Fever.................... ☐ Yes ☐ No
Sinus Trouble................. ☐ Yes ☐ No
Skin Rash......................... ☐ Yes ☐ No
Special Diet....................... ☐ Yes ☐ No
Swollen Neck Glands....... ☐ Yes ☐ No
Thyroid Problems........... ☐ Yes ☐ No
Tonsillitis.......................... ☐ Yes ☐ No
Tuberculosis.................... ☐ Yes ☐ No
Tumor of Head/Neck....... ☐ Yes ☐ No
Ulcer................................ ☐ Yes ☐ No
Venereal Disease............ ☐ Yes ☐ No
Weight loss, unexplained ☐ Yes ☐ No

### WOMEN

Are you Pregnant?........... ☐Yes ☐ No
Due Date__________________
Is there a possibility of pregnancy?
☐ Yes ☐ No : Nursing ☐ Yes ☐ No