

Patient Name (Last, First, Middle Initial)	Date of Birth
Physician Name	Physician Phone

**Medication/Supplement List**  
 List all medications, herbal remedies and nicotine replacement therapy you are taking, including over-the-counter:

Medical History	Yes	No
1. Does your physician recommend that you receive antibiotic premedication for dental care?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you now, or have you been in the last year, under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had any serious illness, operation, or been hospitalized in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a history of Endocarditis (infected heart valve)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had open heart surgery?.	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had an orthopedic total joint replacement (hip, knee, elbow, finger)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had any radiation therapy or chemotherapy for a growth tumor or other condition?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you taking prescription medications to manage pain daily or regularly?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, are you on a 'Pain Contract'?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you use or have you ever used tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, <input type="checkbox"/> Past Use <input type="checkbox"/> Current Use		
10. Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you use any substances for recreational purposes (marijuana, prescription or street drugs, other substances)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you taken, or are you scheduled to be taking oral bisphosphonates (Alendronate-Fosamax, Fosamax Plus D, Etidronate-Didronel, Ibandronate-Bonvia, Risedronate-Acetone, Tiludronate-Skelid)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you taken/taking or are scheduled to begin taking intravenous biophosphonates (Clodronate-Benefos, Pamidronate-Aredia or Zolodronic Cid-Reclast, Zometa)?	<input type="checkbox"/>	<input type="checkbox"/>

**Women Only:**

14. Are you pregnant?	If Yes, How Many Weeks?	Due Date:	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you trying to become pregnant?			<input type="checkbox"/>	<input type="checkbox"/>
16. Are you nursing?			<input type="checkbox"/>	<input type="checkbox"/>
17. Are you taking birth control pills, fertility drugs or hormonal replacement?			<input type="checkbox"/>	<input type="checkbox"/>

**Medical Conditions**

Do you have any of the following diseases, problems or symptoms?

18. Cardiovascular/heart problem (heart attack, heart murmur, high blood pressure, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
19. Respiratory/Lung problem (asthma, emphysema, COPD, tuberculosis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
20. Diabetes/Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
21. Kidney/Urogenital Disorder (renal failure, dialysis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
22. Cancer or Tumors	<input type="checkbox"/>	<input type="checkbox"/>
23. Neurological/Nerve problem (stroke, seizures, MS, mental health disorders, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
24. Blood/Hematologic disorder (anemia, leukemia, bleeding disorders, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

## Medical & Dental History Continued

	Yes	No
25. Gastrointestinal (GI) Disorder (hepatitis, acid reflux, Crohn's, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
26. Musculoskeletal/Connective tissue disorder (arthritis, osteoporosis, fibromyalgia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
27. Growth/Development problem (developmental delay, learning disability, behavioral problems, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
28. Infectious disease (HIV/AIDS, MRSA, cold sores, STDs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
29. Head/Eye/Ear/Nose/Throat problem (glaucoma, cataract, hearing impairment, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
30. Eating disorder (anorexia, bulimia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
31. Immunosuppression (compromised immune system)	<input type="checkbox"/>	<input type="checkbox"/>
32. Are all immunizations/vaccinations up to date?	<input type="checkbox"/>	<input type="checkbox"/>
33. Do you have any other problem, disease or condition not listed?	<input type="checkbox"/>	<input type="checkbox"/>
34. Are you allergic to or have you had a reaction to any substance or medication?	<input type="checkbox"/>	<input type="checkbox"/>
List all substances/medications you are allergic to:	Reaction:	

## Dental History

1. Chief Complaint?		
2. Date of your last dental visit:	3. What was done at that time?	
4. Date of your last dental x-rays:	5. Date of your last dental cleaning:	
6. Are you currently experiencing any dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have swelling in or around your mouth, face or neck?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have loose teeth?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have bad breath, metallic taste or unpleasant taste?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have any clicking, popping or discomfort in your jaw?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you clench, brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have sores, ulcers or tumors in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you had any periodontal treatments? (deep cleaning/gum surgery)	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever had orthodontic treatment? (braces, retainers)	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had local anesthetic (numbing) for dental purposes?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, have you experienced any problems?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you had problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
18. How often do you brush your teeth?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Once a day <input type="checkbox"/> Twice a day <input type="checkbox"/> More than twice a day	
19. How often do you floss your teeth?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Once a day <input type="checkbox"/> Twice a day <input type="checkbox"/> More than twice a day	
20. Do your gums bleed when you brush or floss?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Always	
21. Do you have any obstacles to cleaning or caring for your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
22. Rate your fear of dental treatment on a scale of 0 (no fear) to 10 (extreme fear):		
0   1   2   3   4   5   6   7   8   9   10		
23. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?		
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always		
24. Do you have any previous or present activities or behaviors that may place you at risk for facial injury?	<input type="checkbox"/>	<input type="checkbox"/>