Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?			
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?			
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?			
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?			
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			

WOMEN ONLY Are you:

	Yes	No	DK
Pregnant?			
Number of weeks: _____			
Taking birth control pills or hormonal replacement?			
Nursing?			

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____			
Aspirin _____			
Penicillin or other antibiotics _____			
Barbiturates, sedatives, or sleeping pills _____			
Sulfa drugs _____			
Codeine or other narcotics _____			
Metals _____			
Latex (rubber) _____			
Iodine _____			
Hay fever/seasonal _____			
Animals _____			
Food _____			
Other _____			

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve			
Previous infective endocarditis			
Damaged valves in transplanted heart			
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD			
Repaired (completely) in last 6 months			
Repaired CHD with residual defects			

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease			
Angina			
Arteriosclerosis			
Congestive heart failure			
Damaged heart valves			
Heart attack			
Heart murmur			
Low blood pressure			
High blood pressure			
Other congenital heart defects			

	Yes	No	DK
Mitral valve prolapse			
Pacemaker			
Rheumatic fever			
Rheumatic heart disease			
Abnormal bleeding			
Anemia			
Blood transfusion If yes, date: _____			
Hemophilia			
AIDS or HIV infection			
Arthritis			

	Yes	No	DK
Autoimmune disease			
Rheumatoid arthritis			
Systemic lupus erythematosus			
Asthma			
Bronchitis			
Emphysema			
Sinus trouble			
Tuberculosis			
Cancer/Chemotherapy/ Radiation Treatment			
Chest pain upon exertion			
Chronic pain			
Diabetes Type I or II			
Eating disorder			
Malnutrition			
Gastrointestinal disease			
G.E. Reflux/persistent heartburn			
Ulcers			
Thyroid problems			
Stroke			

	Yes	No	DK
Glaucoma			
Hepatitis, jaundice or liver disease			
Epilepsy			
Fainting spells or seizures			
Neurological disorders If yes, specify: _____			
Sleep disorder			
Do you snore?			
Mental health disorders Specify: _____			
Recurrent Infections Type of infection: _____			
Kidney problems			
Night sweats			
Osteoporosis			
Persistent swollen glands in neck			
Severe headaches/ migraines			
Severe or rapid weight loss			
Sexually transmitted disease			
Excessive urination			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments: