



Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

What is the reason you are seeking dental treatment? \_\_\_\_\_

If female, are you pregnant? \_\_\_\_, nursing? \_\_\_\_, taking contraceptives? \_\_\_\_\_

Please read the following and indicate if you have or have had any of the listed conditions and check the appropriate box, **please circle or write in details.**

**Yes No**

Heart issues: heart attack, coronary artery disease, endocarditis, heart murmur/defect, pacemaker, artificial heart valves, surgery, other: \_\_\_\_\_

Breathing issues: asthma, COPD/emphysema/chronic bronchitis, other: \_\_\_\_\_

Tuberculosis or positive TB skin test \_\_\_\_\_

Digestive issues: GERD/reflux, Crohn's disease, IBS, ulcers, surgery \_\_\_\_\_

Stroke, if yes, when \_\_\_\_\_

Immune issues: HIV/ AIDS, auto-immune disorders, other: \_\_\_\_\_

Liver issues: hepatitis A, B, C, D, E, cirrhosis, fatty liver disease, other: \_\_\_\_\_

Cold Sores (Herpes Simplex I)

Issue with blood/bleeding/clotting: hemophilia, anemia, factor V leiden, other: \_\_\_\_\_

ADHD/ADD

Thyroid Problem \_\_\_\_\_

Current or Past Cancer/Tumor \_\_\_\_\_

Artificial Joints

Fainting

Diabetes (type I, type II), if yes, what and when was your last HBA1C \_\_\_\_\_

Neurological problems: epilepsy/seizures, neuralgia, other: \_\_\_\_\_

Mental health issues: anxiety, depression, bi-polar disorder, schizophrenia, other: \_\_\_\_\_

Kidney problems: kidney failure, stones, other: \_\_\_\_\_

Current or past hx of alcoholism, drug addiction, recreational drug use \_\_\_\_\_

Taken Bisphosphonates (Ex. Boniva, Foxamax, Actonel, Atelvia, Reclast etc.)

Dry mouth

Disability (physical or mental that may require accommodation) \_\_\_\_\_

Sleep apnea or snoring

Any medical issues not addressed above? \_\_\_\_\_

Please list all medications, including dosage \_\_\_\_\_

Allergy or adverse reaction to latex or medications? Please list material or medication and describe reaction (hives, anaphylaxis, GI upset, other :) \_\_\_\_\_

Do you use tobacco? \_\_\_ If yes, how much? \_\_\_\_\_

If yes, how motivated are you to quit? (please circle) low 1 2 3 4 5 6 7 8 9 10 high

Do you drink alcohol? \_\_\_ If yes, about how many drinks per week? \_\_\_\_\_

Do you drink fruit juice, soda, energy drinks, coffee or tea with sugar regularly? \_\_\_\_\_

Please tell us about your daily oral hygiene routine \_\_\_\_\_

For children under 12: What is your source of water? (Municipal, Well, Bottled, If municipal, what town do you live in? \_\_\_\_\_)

Patient or Guardian signature: \_\_\_\_\_

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