Patient's Name_____Dr._____

Answers to the following questions are for our records only and will be considered confidential.
Please answer all questions by filling in the blank spaces or circling the appropriate responses.
If you are filling out this form for another adult or child, please indicate your relationship to that adult or child.

Name_____ Relationship_____

1. My last physical examination was on _____

   My last dental examination was on _____

2. Physician's name: Dr. _____ Phone (____)_____ City _____

3. Previous Dentist: Dr. _____ Phone (____)_____ City _____

4. Are you in good health? …….. Yes No

5. Has there been any change in your general health within the past year? …… Yes No

6. Are you now under the care of a physician?…….. Yes No

7. Are you being treated for any problem?……..…. Yes No

8. Have you been hospitalized or had any serious illness or operation?…… Yes No
   If so, what was the problem? _____

9. Are you pregnant?…… Yes No

10. List any medications or drugs you are taking:_____

11. List any medications or drugs you cannot take: _____

12. Are you currently taking any form of blood thinners? ie plavix, coumadin, pradaxa, aspirin, _____

13. *Do you need to **pre-medicate** before appointments? Yes _____ No _____

Have you ever had any of the following? (Please check the appropriate answers)

Yes	No		Yes	No		Yes	No	
___	___	Rheumatic fever	___	___	Arthritis	___	___	Bruise easily
___	___	Heart disease	___	___	Neurological disorder	___	___	Been told you snore
___	___	Pacemaker	___	___	Mental disturbances	___	___	Bleeding disorder
___	___	Prosthetic heart valves	___	___	Fainting spells	___	___	Hemophilia
___	___	Joint replacements	___	___	Nervousness	___	___	Anemia
___	___	Hydrocephalic shunt	___	___	Seizures or epilepsy	___	___	Sickle cell anemia
___	___	Dialysis shunt	___	___	Stomach ulcers	___	___	Cancer
___	___	High Blood Pressure	___	___	Chronic Fatigue	___	___	Acid Reflux/Gerd
___	___	High Cholesterol	___	___	Kidney disease	___	___	Any tumors
___	___	Low blood pressure	___	___	Kidney transplant	___	___	Cold sores
___	___	Chest pain upon exertion	___	___	Diabetes	___	___	Alcohol usage
___	___	Shortness of breath	___	___	Dry mouth	___	___	Drug Abuse
___	___	Swollen ankles	___	___	Frequent thirst or urination	___	___	Birth control pills
___	___	Allergies	___	___	Other metabolic disorders	___	___	Problems with menstruation
___	___	Asthma	___	___	Abnormal bleeding	___	___	Thyroid disorder
___	___	Hives or skin rash	___	___	Hay fever	___	___	mood disorder/depression
___	___	have trouble sleeping	___	___	sleep apnea	___	___	heart attack

Has any family member (parent, sibling, grandparent) ever had any of the following? Please check the appropriate answers.

___ Cancer	___ Sleep disorder	___ Diabetes	___ Thyroid disorder	___ Father snores
___ Heart disease	___ High blood pressure	___ Stroke	___ Mother snores	