

1. Are you now or have you been under a physician's care within the past year? YES NO

If YES, specify condition being treated and date of last exam: _____

2. Are you taking any medications including over the counter pain pills and/or herbal supplements and/or vitamins? YES NO

Please list ALL medications, vitamins and supplements (and dosage of each) you are currently taking:

3. Have you ever had an unusual reaction or are you allergic to any of the following drugs?

Acetamin Aspirin Codeine Ibuprofen Latex Other Penicillin Seasonal allergies Sulfa

4. Please list any other drug or food allergies: _____

5. Are you allergic to any local anesthetics? YES NO

If yes, please explain anesthetic allergy/experience: _____

6. Have you ever had a heart attack? YES NO

7. Do you or have you ever had any heart or blood conditions? YES NO

8. Have you ever been told you have a heart murmur? YES NO

9. Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? YES NO

10. Have you been diagnosed with high blood pressure? YES NO

11. Have you ever had a stroke? YES NO

12. Are you currently being treated for any form of cancer? YES NO

If yes, please specify the type of cancer: _____

List the name of the treating physician, and their contact information: _____

13. Have you ever been diagnosed with Tuberculosis? YES NO

Are you currently receiving treatment? YES NO

If so, please include the name and contact information of your treating physician: _____

If you are in remission, please provide the date of your last test: _____

14. Do you bleed or bruise easily? YES NO

15. Have you ever been diagnosed as being HIV positive or having AIDS? YES NO

16. Have you ever been diagnosed with hepatitis or liver disease? YES NO

If yes, Hepatitis A Hepatitis B Hepatitis C Other

17. Have you ever been diagnosed for any of the following:

Arthritis Asthma Blood Disorder Diabetes Heart Attack Immune System

Disorders Kidney Disease Rheumatic Fever Rheumatism Venereal Disease

Any other condition not listed: _____

18. Are you subject to fainting? YES NO

19. Have you ever had a severe reaction to dental treatment or local anesthetics? YES NO

20. Have you ever had a nervous breakdown or undergone psychiatric treatment? YES NO

21. Have you ever been treated for or received counseling for use of
alcohol and/or perscription drugs? YES NO

22. Women: Are you pregnant or currently trying to become pregnant? YES NO

23. Have you ever taken Phen-Fen or similar appetite suppressants? YES NO

If YES, have you seen your physican or cardiologist for a cardiac evaulation? YES NO

24. Have you ever used or currently use any kinds of tobacco products or vape? YES NO

How often: _____ How many packs a day: _____

25. Do you consume alcohol? YES NO

How often: _____

26. Have you ever taken Fosamax, Actonel, Boniva, or any other drugs per-
scribed to decrease the resorption of bone as in Osteoporosis or any drugs for
Metastatic Bone Cancer? YES NO

27. Are you currently in any dental pain? YES NO

28. When was the last time you visited the dentist? _____

29. Do you feel that your teeth are affecting your general health in any way? YES NO

30. Do your gums bleed easily? YES NO
31. Are you taking any blood thinners? YES NO
- If yes, please list: _____
32. Does your diet consist of a lot of sugary foods or liquids? YES NO
33. Do you have fear or anxiety when going to the dentist? YES NO
34. If you could change anything about your smile, what would it be? (check all that apply)
- Whiter smile Straighter teeth Healthier gums
35. Do you think you clench your teeth at night? YES NO
36. Do you wake up with a headache? YES NO
37. Do you wake up with a sore jaw? YES NO
38. Do you snore or have you ever been diagnosed with sleep apnea? YES NO
39. Do you wear a C-PAP or have you in the past? Have you been told to? YES NO
40. Have you had a sleep study or been told to get a sleep study? YES NO
41. Do you use over the counter medication for headache pain or a sleeping aid? YES NO
42. Is it easy for you to get to sleep? YES NO
- How many times do you wake? _____
43. Do you feel rested when you wake in the morning? YES NO
44. Do you experience sounds like popping or clicking in the jaw joints? YES NO

Print Name: _____ Date: _____

Patient Signature: _____

Guardian Signature: _____

Office Witness: _____ Date: _____