Name: _____ **Today's Date:**_____

Address:_____ **Home phone:** _____

_____ **Work phone:** _____

Email address:_____ **Cell #**_____

Employer: _____ **Date of Birth:**_____

Primary Care Physician_____**Phone #**_____

Are You Allergic to any of the following? Please Circle Y or N for each.

Y N Aspirin Y N Erythromycin Y N Penicillin
Y N Codeine Y N Jewelry/Metals Y N Tetracycline
Y N Dental Anesthetics Y N Latex Y N Other _____

Has anyone ever told you that you snore? Y N Do you have restless leg syndrome Y N Do you often wake up short of breath? Y N Do you often wake up feeling exhausted Y N

Are you happy with the way your smile looks? Y N Would you like fresher breath? Y N Whiter Teeth? Y N

Abnormal Bleeding /Hemophilia	Y	N	Herpes/Fever Blisters	Y	N
AIDS	Y	N	High Blood Pressure	Y	N
Alcohol/Drug Abuse	Y	N	HIV+	Y	N
Anemia	Y	N	High Cholesterol	Y	N
Arthritis	Y	N	Hospitalized for Any Reason since your last visit?	Y	N
Artificial Bones/Joints/Valves	Y	N	Kidney Problems/Dialysis	Y	N
Asthma	Y	N	Liver Disease	Y	N
Blood Transfusion	Y	N	Low Blood Pressure	Y	N
Cancer/Chemotherapy	Y	N	Lupus	Y	N
Colitis	Y	N	Pacemaker	Y	N
Congenital Heart Defect	Y	N	Psychiatric problems	Y	N
Diabetes	Y	N	Radiation Treatment	Y	N
Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever	Y	N
Emphysema	Y	N	Seizures	Y	N
Epilepsy	Y	N	Shingles	Y	N
Fainting Spells	Y	N	Sickle Cell Disease/Traits	Y	N
Frequent Headaches	Y	N	Sinus Problems	Y	N
Glaucoma	Y	N	Stroke	Y	N
Hay Fever	Y	N	Thyroid Problems	Y	N
Heart Attack/Heart Surgery/Stent Placed	Y	N	Tuberculosis (TB)	Y	N
Heart Murmur/Mitral Valve Prolapse	Y	N	Ulcers	Y	N
Hepatitis	Y	N	Venereal Disease	Y	N
Treatment for Osteoporosis: What medication? How long ?	Y	N	Please list any other medical conditions that are not listed above:		

Do You Smoke or Use Tobacco in any other form?
_____ _

Have you had any metal rods, pins or implants?
_____

Have you ever taken Phen-Fen? Also known as Redux or Pondimin.
_____

If So, When?
_____

Please List all prescription medications/and or Herbal Supplements you are taking: If you have a list, please provide a copy.
_____
_____

List all over-the-counter drugs you are currently taking:
_____
_____
_____

For Women:
Are you taking birth control pills? Y N
Are You Pregnant? Y N
Are you nursing? Y N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature_____ Date_____

Doctor Signature_____ Date_____