Name_____Age_____ Date_____

Date of last health care exam _____ What was the exam for? _____

Have you been hospitalized or have had surgery? Yes No If so for what? _____

Are you currently receiving treatment? Yes No If so for what? _____

List all the names and phone numbers of the physicians who you are currently under the care of:

1. _____
2. _____
3. _____
4. _____

Do anesthetics make you nauseous? Yes No Have you had trouble from previous dental care? Yes No

If yes explain: _____

Former Dentist _____ Date of last dental exam? _____

Circle Yes or no for the following questions

Blood Disorders	No	**Yes**	Hepatitis – Any form	No	**Yes**
Arthritis, Rheumatism or other inflammatory	No	**Yes**	Joint Replacement? If so when	No	**Yes**
Asthma, COPD or Lung Disease	No	**Yes**	Kidney Disease	No	**Yes**
Abnormal Bleeding from cuts or Bruise Easily	No	**Yes**	Liver Disease	No	**Yes**
Cancer or Tumor	No	**Yes**	Sore/Enlarged Lymph Nodes	No	**Yes**
Diabetes	No	**Yes**	Psychiatric Therapy	No	**Yes**
Emphysema or Respiratory Illness	No	**Yes**	Biopsies	No	**Yes**
Epilepsy	No	**Yes**	Radiation or Chemotherapy	No	**Yes**
Fainting or Dizzy Spells	No	**Yes**	Renal Dialysis	No	**Yes**
Glaucoma	No	**Yes**	Slow Health Mouth Sores	No	**Yes**
Previous Bacterial Endocarditis	No	**Yes**	Unintentional Weight Loss or Gain	No	**Yes**
Heart Valve (artificial) or Heart Transplant	No	**Yes**	HIV Infection/AIDS or ARC	No	**Yes**
Congenital Heart Disease	No	**Yes**	Venereal Disease	No	**Yes**
Heart Attack, Heart Surgery, Angina	No	**Yes**	Recurrent Illnesses	No	**Yes**
Heart Stent? If so when placed	No	**Yes**	Other Conditions? If so what?	No	**Yes**

Are you taking any of these Medications?

Pre-medication before dental treatment	No	**Yes**	Tagamet (Cimetidine), Prilosec (Omeprazole)	No	**Yes**
Antacids	No	**Yes**	Cardizem (Diltiazem), Calan, Isoptin (Varapamil)	No	**Yes**
St. John's Wart or Kava-Kava	No	**Yes**	Serzone (Nefazodone)	No	**Yes**
Dilantin or Tegretol	No	**Yes**	Diflucan (Fluconazole, Sporonox (Itraconazole)	No	**Yes**
Barbiturates (ANY)	No	**Yes**	Biaxin	No	**Yes**

Have you been treated with Bisphosphonate drugs? (Fosamax, Aredia, Zometa, Actonel, Boniva, Reclast or Prolia. If so when did the treatment begin?_____ When did it end? _____	No	**Yes**
Have you ever taken any prescription drugs such as fen-phen for weight loss?	No	**Yes**
D you consume grapefruit juice, grapefruits, or grapefruit extract?	No	**Yes**

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3_____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking and for what purpose:

1. _____ 2. _____
3_____ 4. _____

Woman: Are you pregnant?

If no, are you planning a pregnancy in the near future? Yes No
Are you a nursing mother? Yes No
Are you taking birth control pills? Yes No

Blood Pressure:

Have you ever received a diagnosis of "high or low" blood pressure? Yes No
Do you know your normal blood pressure? If so what is it? _____

Are you allergic or have you had a reaction?

Local anesthetic or epinephrine	No	**Yes**
Penicillin or other antibiotics	No	**Yes**
Aspirin, Ibuprofen or Tylenol	No	**Yes**
Codeine, Valium, Hydrocodone, Oxycodone or other sedatives	No	**Yes**
Latex or Metals	No	**Yes**
Other (Please specify) _____	No	**Yes**

Tobacco, Alcohol and Drugs

Do you use tobacco? If yes, circle type: Smoke or Chew How much per day? For how long?	No	**Yes**
Do you want to quit using tobacco?	No	**Yes**
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	**Yes**
Do you use any mood altering drugs other lhan those previously listed?	No	**Yes**

Weight & Diet Considerations

Weight _____ Height _____ Meals per day _____ Dietary Restrictions _____

Food Allergies _____ Sugar in your diet (Circle one): None Slight Moderate High

Doctor's Use Only

Comments on patient interview concerning medial history:

_____
_____
_____
_____

Significant findings from questionnaire or oral interview:

_____
_____
_____
_____

Dental management considerations:

_____
_____
_____
_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication(s).

_____	_____	_____
PRINT – Patient Name	Patient Signature	Date

_____	_____
Dr. Kelly Truong	Date