The answers to the following questions are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some additional questions about your responses to this questionnaire.

Current Medications_____

_____

Do you require antibiotics prior to dental treatment? Yes No Reason:_____
Are you allergic to any of the following: Latex ☐ Penicillin☐ Codeine☐ Asprin ☐ Metals ☐ Acrylic☐
Are you currently under a physician's care? If so, please explain: _____
Have you been hospitalized or had any surgery in the last 5 years? Please explain. _____

_____

Do you smoke or use tobacco products? Yes No If so, How much? _____
Are you pregnant/trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

**Please indicate if you have or have had any of the following:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV + | | Depression | | Hemophilia | | Past Use of PhenFen/Redux | |
| Alcohol/Chemical Dependency | | Diabetes Type: | | Hepatitis<br>Herpes | | Persistent Diarrhea | |
| Angina | | Dialysis | | High Blood Pressure | | Psychiatric Disorders | |
| Anemia | | Eating Disorder | | Immunologic Disorder | | Radiation Treatment | |
| Arthritis | | Emphysema | | Indwelling Defibrillator | | Rheumatic Fever | |
| Artificial Heart Valve | | Epilepsy/Seizures | | Kidney Disease | | Shortness of Breath | |
| Artificial Joints | | Fainting | | Leukemia | | Sinus Trouble | |
| Asthma | | Fibromyalgia | | Liver Disease | | Sjrogens Disease | |
| Autoimmune Disorder | | Glaucoma | | Low Blood Pressure | | Sleep Apnea | |
| Bleeding Problems | | Headaches | | Lung Disease | | Stomach Reflux | |
| Blood Transfusion | | Head/Neck Injury | | Mitral Valve Prolapse | | Stomach Ulcer | |
| Cancer | | Heart Disease | | Neurologic Disorder | | Stroke | |
| Cerebral Palsy | | Heart Murmur | | Organ Transplant | | Thyroid Disease | |
| Chemotherapy | | Heart Surgery | | Osteoporosis | | Tuberculosis | |
| Convulsions | | Heart Trouble | | Pacemaker | | Weight Loss | |

Do you have any disease, condition or problem not listed above? Please explain. _____

_____

Have you had any serious trouble associated with previous dental treatment? _____

_____

Have you ever been treated with bisphosphonate medications? (Fosamax, Actonel, Boniva, Zometa, etc.) Yes No
When? _____

**Dental History**

Last dental visit ___/___/___ Last dental cleaning ___/___/___ Frequency of cleanings _____
What is you chief dental concern?_____
Have you ever had any periodontal treatment? Yes No How long ago?_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any dental services necessary for diagnosis and those necessary for treatment.

_____ ____/____/____
Signature/Signature of parent or guardian Date

Dentist/Staff Review and Notes:

_____
_____
_____
_____