

For the following questions, please circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

Rheumatic Fever	Yes	No	
Heart Murmur	Yes	No	Type: _____
Mitral Valve Prolapse	Yes	No	
Are you required to PRE-MEDICATE before dental treatment?	Yes	No	
PACEMAKER	Yes	No	
Abnormal Heart Condition	Yes	No	Specify: _____
Heart (surgery, disease, attack)	Yes	No	Specify: _____
Stroke	Yes	No	
Abnormal Blood Pressure	Yes	No	Specify: _____
Anemia	Yes	No	
Abnormal Bleeding from a cut	Yes	No	
Diabetes	Yes	No	Type: _____
Hyper/Hypoglycemia	Yes	No	
Epilepsy	Yes	No	
Asthma	Yes	No	
Emphysema/respiratory illness	Yes	No	
Tuberculosis	Yes	No	
Hepatitis	Yes	No	Type: _____
Liver Disease (including Jaundice)	Yes	No	
HIV positive	Yes	No	
AIDS or AIDS related complex	Yes	No	
Venereal Disease or any STDs	Yes	No	
Unintentional Weight Loss/Gain	Yes	No	
Blood Transfusion	Yes	No	Year of transfusion: _____
Kidney Disease	Yes	No	
Psychosis	Yes	No	
Cancer	Yes	No	Type: _____
Previous Biopsies	Yes	No	
Reason for biopsy:	_____		
Radiation Treatment	Yes	No	
If yes, reason for treatment:	_____		
Chemotherapy Treatment	Yes	No	
If yes, reason for treatment:	_____		
Sore/Enlarged Lymph Nodes	Yes	No	
Slow Healing Mouth Sores	Yes	No	
Glaucoma	Yes	No	
Headaches	Yes	No	Type: _____
Thyroid Problems	Yes	No	
Arthritis	Yes	No	Type: _____
JOINT REPLACEMENT	Yes	No	If yes, what joint(s): _____
Date of joint replacement surgery?	_____		

Please list **any** medication you are currently taking and what *you* are taking it for:

Have you ever been treated with any long-term antibiotic medicines? Yes No

If yes, please provide name of antibiotic: _____

Do you take Antacids? Yes No How often: _____

Do you or have you experienced excess stomach acid? Yes No

Are you taking any vitamins, herbal supplements/medications? Yes No

If yes, please list: _____

Are you on a restricted diet? Yes No

If yes, please describe: _____

How many meals do you eat a day? _____

Do you have any food Allergies? Please list _____

Amount of sugar in your diet: None Slight Moderate High

Amount of sodium in your diet: None Slight Moderate High

Are there any prior dental office experiences you would like to share with us? Yes No

Is there anything you would like us to know about your dental health?

Do you have any questions about your teeth?

Please add any information you feel is important for us to know:

Signature: _____

For Doctor's use only:

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management consideration: _____