

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To yes responses, specify type of reaction. _____

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when was this operation done? _____			
If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?			

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what antibiotic and dose? _____			
Name of physician or dentist*? _____			
Phone: _____			

WOMEN ONLY

Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills or hormonal replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know		Yes	No	Don't Know
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, indicate type of infection: _____			
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion. If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mainutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Angina				Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Arteriosclerosis				Persistent swollen glands in neck			
___ Artificial heart valves				Respiratory problems. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Congenital heart defects				___ Emphysema			
___ Congestive heart failure				___ Bronchitis, etc.			
___ Coronary artery disease				Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Damaged heart valves				Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Heart attack				Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disease, drug, or radiation-induced immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores or ulcers in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Type I (Insulin dependent)				Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Type II				Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease, condition, or problem not listed above that you think I should know about?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please explain: _____			
G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ DATE _____

FOR COMPLETION BY DENTIST

Comments on patient interview concerning health history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist
_____	_____	_____
_____	_____	_____