Patient Name _____ Date _____

Confidential Dental and Health Record

Dental complaint at the moment (symptoms?) _____

Please answer the following Y/N Questions:

	Yes	No	
1.	___	___	Do you ever have pain or muscle aches near the jaws?
2.	___	___	Do hot or cold foods or liquids cause pain in your mouth?
3.	___	___	Have you had any abnormal experiences with local anesthetic in the past?
4.	___	___	Do you take any medications (list)? _____ _____ _____
5.	___	___	Are you allergic to any medications (list)? _____
6.	___	___	Are you allergic to latex?
7.	___	___	Have you taken any type of bisphosphonate medication (oral/I.V.) as a treatment for osteoporosis, multiple myeloma, metastatic breast, lung or prostate cancer?
8.	___	___	Do you suffer from asthma, chronic bronchitis, or emphysema (circle those that apply)?
9.	___	___	Are you a diabetic or does diabetes run in your family (If yes, circle those that apply)?
10.	___	___	Have you had chest pains or swelling of the legs?
11.	___	___	Do you have a history of heart disease, rheumatic fever, high blood pressure, or anemia? (If yes, circle those that apply).
12.	___	___	Have you had any liver disease, hepatitis, or jaundice? (If yes, circle those that apply)
13.	___	___	Do you have any disease of the thyroid gland?
14.	___	___	Do you have any kidney diseases or infections?
15.	___	___	Do you have any stomach or intestinal problems?
16.	___	___	Do you suffer from any autoimmune disorders such as rheumatoid arthritis, Addison's Disease, multiple sclerosis, Sjogren's syndrome, or lupus? (circle those that apply)
17.	___	___	Have you had any severe emotional problems or psychiatric treatment?
18.	___	___	Do you presently have a venereal disease or history of AIDS or HIV?
19.	___	___	Do you have a heart valve murmur or mitral valve prolapse?
20.	___	___	Do you have any artificial joints? (If yes, date of surgery _____ Any complications? _____ (If yes, please explain _____
21.	___	___	Do you require, or have you ever been told that you need antibiotic prophylaxis for dental treatment due to a heart condition, joint replacement, or any other medical condition?
22.	___	___	Are you taking any dietary supplements? (i.e. weight loss or herbal?)
23.	___	___	Have you had any current major health problem, extensive illnesses, hospitalization, or surgeries that have not been covered in the above questions? _____ _____ _____
24.	___	___	(Women) Are you pregnant, might be pregnant, trying to get pregnant, or breastfeeding? (If yes, circle those that apply)
25.	___	___	(Women) Are you currently taking birth control pills?

By giving your signature, you are stating that the above information is up to date and accurate to the best of your knowledge.

Signature: _____