



Name \_\_\_\_\_ Date of birth \_\_\_\_\_

List all medications you are currently taking, including supplements and oral contraceptives.

\_\_\_\_\_

\_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Do you take antibiotics before dental treatment?      No      Yes

If yes, please specify which medication and why \_\_\_\_\_

\_\_\_\_\_

**Health History (please check all that apply)**

Do you take medication for or have high blood pressure?      No      Yes

BP Today \_\_\_\_\_

Diabetes: Type I      Type II      None

Last A1C: \_\_\_\_\_ Approx. date: \_\_\_\_\_

Are you taking blood thinners?      No      Yes

Please specify reason (e.g. stroke) \_\_\_\_\_

ADD/ADHD      Anxiety      Depression      Insomnia      None

Anemia      No      Yes

Arthritis      No      Yes

Asthma      No      Yes

Autoimmune Disease/Rheumatism      No      Yes

Please Specify \_\_\_\_\_

Cancer      No      Yes

Please specify type and date \_\_\_\_\_

Are you currently receiving or have you ever received radiation?      No      Yes

Congenital Heart Disease      No      Yes

COPD      No      Yes

Dementia      No      Yes

Epilepsy      No      Yes

Fainting or Dizzy Spell      No      Yes

Frequent Headaches      No      Yes

Gastric Reflux      No      Yes

Glaucoma      No      Yes

Heart Attack      No      Yes

Please specify date \_\_\_\_\_

Heart Valve (replacement or repair)      No      Yes

Hepatitis      No      Yes

Please specify type \_\_\_\_\_

Herpes: Oral      Genital      No      Yes

HIV/AIDS      No      Yes

Hypo/Hyperthyroidism      No      Yes

Joint Replacement?      No      Yes

Please specify type \_\_\_\_\_

Kidney Disease      No      Yes

Liver Disease      No      Yes

Muscle/Connective Tissue Disorder      No      Yes

Osteoporosis/Osteopenia      No      Yes

Have you ever taken bisphosphonates?      No      Yes

Are you pregnant? Which trimester? \_\_\_\_\_      No      Yes

Previous Endocarditis/Rheumatic Fever      No      Yes

Sleep Apnea/Snoring      No      Yes

**Allergies**

Aspirin, Ibuprofen, or any other NSAIDs      No      Yes

Latex      No      Yes

Local Anesthetics      No      Yes

Penicillin or other Antibiotics      No      Yes

Other      No      Yes

Please Specify \_\_\_\_\_

**Tobacco, Alcohol, Drugs**

Do you smoke, vape, or chew tobacco products?      No      Yes

Do you consume alcohol?      No      Yes

How much/often? \_\_\_\_\_

Do you use any mood-altering or recreational drugs?      No      Yes

Please List \_\_\_\_\_

Patient (print name) \_\_\_\_\_ Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor (print name) \_\_\_\_\_ Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_