

Patient Name: _____
Reviewed by: _____
Date: _____ ASA: _____



Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve		
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/			Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood			Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

Are you taking any of the following?

<input type="checkbox"/> Blood Thinners	<input type="checkbox"/> Aspirin daily	<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Cortisone (Steroid)
<input type="checkbox"/> Digitalis (Heart Medication)	<input type="checkbox"/> Insulin(Diabetes Medication)	<input type="checkbox"/> High Blood Pressure Medication	<input type="checkbox"/> Nitroglycerine
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Antihistamine
<input type="checkbox"/> Thyroid Medication	<input type="checkbox"/> Other _____		

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Codeine	<input type="checkbox"/> Dental Anesthetics
<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Latex	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sedatives
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Tetracycline		

Please list additional drugs/materials that cause allergic reactions: _____

General Health

	Yes	No		Yes	No
Pregnant or trying to become	<input type="checkbox"/>	<input type="checkbox"/>	Taking Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
Do you require antibiotics for dental appointment	<input type="checkbox"/>	<input type="checkbox"/>			
Physician's name: _____	Physician's contact number: _____				
Date of last physical: _____					

Dental Questionnaire

What are your feelings about your teeth?

Are you happy with their color?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you happy with their length?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are they crowded or crooked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are braces an option for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anything about them you would change? _____			
Do you experience frequent headaches, jaw clicking or popping? <input type="checkbox"/> Yes <input type="checkbox"/> No			

What is the first thing that you would like for us to help you with? _____

Is there anything that would stand in the way of getting the dental care that you need? _____

Has fear kept you from seeking dental care? Yes No

Would you be interested in sedation dentistry? Yes No

What do you fear most about dental care? _____