Do you have a personal physician? **Yes No**
Physicians name:_____
Ph. #_____ Date last visit_____
Your current Physical health **Good Fair Poor**
Are you currently under the care of a physician? **Y N**
Please explain:_____
_____
_____
_____

Are you taking any prescription/ over the counter drugs?
**Y N** Please list each one:_____
_____
_____

**Are you allergic to any of the following drugs?**
**Y N** Penicillin **Y N** Tetracycline **Y N** Latex
**Y N** Aspirin **Y N** Codeine **Y N** Sulfa
**Y N** Erythromycin **Y N** Dental Anesthetics
**Y N** Other **List any other drugs you are allergic to:**
_____
_____
_____

**Have you ever had any of the following diseases or medical problems?**

| | | | |
|---|---|---|---|
| **Y N** | Heart Attack | **Y N** | Tuberculosis (TB) |
| **Y N** | Stroke | **Y N** | Epilepsy |
| **Y N** | Cancer/ Chemotherapy | **Y N** | Seizures |
| **Y N** | Heart murmur | **Y N** | Fainting spells |
| **Y N** | Rheumatic Fever | **Y N** | Previous drug/ |
| **Y N** | Heart problems | | Alcohol abuse |
| **Y N** | HIV / AIDS | **Y N** | Heart surgery |
| **Y N** | Hemophilia/ Abnormal bleeding | | |
| **Y N** | Pacemaker | **Y N** | Ulcers |
| **Y N** | Mitral Valve Prolapse | **Y N** | Colitis |
| **Y N** | Kidney/ Liver problems | | |
| **Y N** | Artificial bones/joints | **Y N** | Congenital heart defect |
| **Y N** | Artificial valves | **Y N** | Radiation treatment |
| **Y N** | Sinus problems | **Y N** | Asthma |
| **Y N** | High blood pressure | **Y N** | Arthritis |
| **Y N** | Low blood pressure | **Y N** | Blood transfusion |
| **Y N** | Hospitalized for any reason | | |
| **Y N** | Fever blisters | **Y N** | Hepatitis A |
| **Y N** | Psychiatric problems | **Y N** | Hepatitis B |
| **Y N** | Diabetes | **Y N** | Glaucoma |
| **Y N** | Respiratory Problems | **Y N** | ADD |
| **Y N** | Do you snore | **Y N** | ADHD |

**Y N** Do you have sleep apnea?
**Y N** Have you ever taken Fosamax, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer?
**Please let us know about any serious medical condition(s) you have ever had**:_____
_____
_____

| | | |
|---|---|---|
| Problems of the jaw | **Y** | **N** |
| Clicking of the jaw | **Y** | **N** |
| Pain (joins, ear, side of face) | **Y** | **N** |
| Difficulty opening or closing | **Y** | **N** |
| Difficulty Chewing | **Y** | **N** |

**Are your teeth sensitive to:**

| | | |
|---|---|---|
| Hot or cold | **Y** | **N** |
| Sweets | **Y** | **N** |
| Biting Pressure | **Y** | **N** |

Have you ever had a reaction to local anesthetic?
**Y N**

If there was one thing you could change about your teeth, what would it be?_____
_____
_____

Do you use tobacco products? **Y N**
Have you ever had any teeth removed
**Y N**
Do you have any other fears or concerns?
**Y N** _____
_____
_____

What is your present dental problem?_____
_____
_____
_____

What do you see for your teeth in the future (i.e. in 5, 10, 15 years)? _____
_____
_____
_____

What would you like your teeth to look like?
_____
_____
_____

**FOR WOMEN**
Are you taking birth control pills? **Y N**
Are you pregnant? **Y N**
Week # if yes _____
Are you nursing? **Y N**

**Signature:**
_____
**Date**:_____