1. *Are you having dental problems at this time?* _____ ☐ Yes ☐ No
2. *Do your gums bleed at any time?* ☐ Yes ☐ No
3. *Do you feel very nervous about dental treatment?* ☐ Yes ☐ No
4. *Have you ever had a bad experience in the dental office?* ☐ Yes ☐ No
5. *Have you been under the care of a medical doctor during the past two years?* ☐ Yes ☐ No
   If yes, for what reason? _____
   Please provide the name, address, and telephone number of your physician. _____
   _____
6. *Have you been in the hospital during the past two years?* ☐ Yes ☐ No
   If yes, for what reason? _____
7. *Do you take medicine on a daily basis?* ☐ Yes ☐ No
   If yes, please list:
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
8. *Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, latex, aspirin, codeine, or any drugs or medicines?* ☐ Yes ☐ No
   If yes, please list: _____ _____ _____ _____
9. *Have you ever had excessive bleeding requiring special treatment?* ☐ Yes ☐ No
10. *Do you use tobacco products?* ☐ Yes ☐ No
11. *Are you taking antidepressants?* ☐ Yes ☐ No
12. *Do you take anticoagulants or blood thinners?* ☐ Yes ☐ No
13. *Do you snore?* ☐ Yes ☐ No
14. *Have you had teeth removed?* ☐ Yes ☐ No
15. *Do you have* ☐ *dentures* ☐ *partials* ☐ *crowns* ☐ *implants?*
16. *Do you premedicate with antibiotics for dental procedures?* ☐ Yes ☐ No
17. *Are you taking any medications for osteoporosis?* ☐ Yes ☐ No
18. *Check any of the following which apply in either past or present:*

Yes	No		Yes	No		Yes	No	
☐	☐	*Mitral Valve Prolapse*	☐	☐	*High Blood Pressure*	☐	☐	*Arthritis*
☐	☐	*Heart Failure*	☐	☐	*Anemia*	☐	☐	*Pain in Jaw Joints*
☐	☐	*Heart Disease or Attack*	☐	☐	*Asthma*	☐	☐	*X-ray or Cobalt Treatment*
☐	☐	*Angina Pectoris (chest pain)*	☐	☐	*Emphysema*	☐	☐	*Cancer or Tumors*
☐	☐	*Rheumatic Fever*	☐	☐	*Food Allergies*	☐	☐	*Chemotherapy (Cancer, Leukemia)*
☐	☐	*Scarlet Fever*	☐	☐	*Allergies or Hives*	☐	☐	*Thyroid Disease*
☐	☐	*Artificial Heart Valve*	☐	☐	*Fainting or Dizzy Spells*	☐	☐	*Glaucoma*
☐	☐	*Heart Pacemaker*	☐	☐	*Epilepsy or Seizures*	☐	☐	*HIV Positive (AIDS)*
☐	☐	*Heart Surgery / Stent or Bypass*	☐	☐	*Psychiatric Treatment*	☐	☐	*Cold Sores*
☐	☐	*Artificial Joint Any Type*	☐	☐	*Any Form of Eating Disorders*	☐	☐	*Fever Blisters*
☐	☐	*Heart Murmur*	☐	☐	*Drug Addictions / Alcoholism*	☐	☐	*Kidney Trouble*
☐	☐	*Bruise Easily*	☐	☐	*Tuberculosis*	☐	☐	*Diabetes*
☐	☐	*Blood Transfusion*	☐	☐	*Any Form of Hepatitis*	☐	☐	*Stroke*
☐	☐	*Hemophilia*	☐	☐	*Liver Disease*	☐	☐	*Birth Control Medication*
						☐	☐	*Pregnant - Due Date* _____

19. *Do you have any disease, condition or problem not listed? If so, please list:* _____
    _____

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor choose and employ such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered in this office.

Signature _____ *Date* _____

Update _____ _____ _____ _____ _____ _____ _____