Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Primary Language: \_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­\_\_\_\_\_\_ Translator’s Name & Phone#*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Medical Physician’s Name, Phone Number, & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiologist’s Name, Phone Number & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OBGYN’s Name, Phone Number & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy & Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone# \_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* Please Check any conditions (past or present) that apply to you! All answers are completely confidential!**

***\_\_Previous Endocarditis*** *Date: \_\_\_\_\_\_\_\_\_\_\_*  ***\_\_*** Currently Pregnant …*Due Date:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\_\_Artificial Heart Valve***  *Date: \_\_\_\_\_\_\_\_\_\_\_*  \_\_ Currently Nursing/ Breast Feeding

***\_\_Artificial Joint Replacement***: *Type:\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_* \_\_ Currently Taking Birth Control Pills:T*ype*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Joint Complications:* ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** \_\_ Disability of Any Kind …*Type*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\_\_Congenital Heart Defect*** \_\_ Thyroid Disease

**\_\_*AV Shunt/Patent Ductus Arteriosus***  *\_\_*Taken Prednisone/Steroids…*Type/Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***\_\_Transplant*** *Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_* \_\_ Nervousness/Anxiety

***\_\_Any Heart Valve Damage*** *Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_* \_\_ Psychiatric Treatment… *Doctor/Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_***Mitral Valve Prolapse,*** *Complications?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Sinus Issues

\_\_ Cardiac Pacemaker \_\_ Drug Addiction (Any Type)…*Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_ Angina pectoris/Chest pain \_\_ Cirrhosis of Liver

\_\_ High Blood Pressure \_\_ Hepatitis/ yellow jaundice…*Type:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Irregular Heart Beat \_\_ Tuberculosis (TB)… *Circle: Active or Non-Active*

\_\_ Asthma \_\_ Diabetes Type 1 or 2

\_\_ Heart disease or attack \_\_ Work with blood products or needles?

\_\_ Anemia \_\_ Sexually Trans. Disease *Type*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Stroke (Major or Minor) \_\_ HIV-Positive/AIDS:  *CD4 \_\_\_\_\_\_\_\_\_\_\_ Viral Load\_\_\_\_\_\_\_\_\_\_\_*

\_\_ Tendency to Bleed/Blood Thinner \_\_ Dialysis

\_\_ Hemophilia \_\_ Kidney/ Bladder conditions

\_\_ Tumor or Cancer. *Type:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Emphysema

\_\_ Chemotherapy,  *When*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Sickle Cell Disease/ Trait

\_\_ Radiation Therapy: *Date: \_\_\_\_\_\_\_ Entry/Exit Point: \_\_\_\_\_\_\_\_\_\_\_\_\_\_* \_\_ Hearing Impaired

\_\_ Glaucoma or Cataract \_\_ Anorexia or Bulimia

\_\_ Epilepsy or Seizures \_\_ Acid Reflux or GERD

\_\_ Has a Living Will *(Please give to the receptionist)* \_\_ Digestive Conditions…*Type:\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Any Conditions not listed here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_

\_\_ Victim of Violence/Rape/Abuse: *Date: \_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**\_\_** *I want & I am willing to accept HELP/Counseling for Domestic Violence/ Rape/ Abuse of any kind?*

**ARE YOU ALLERGIC TO:**  **DENTAL HISTORY:**

\_\_Latex (rubber) \_\_ I have a dental check up twice a year?

\_\_Local Anesthetics, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ My teeth feel loose or hurt when biting?

\_\_Penicillin \_\_ My gums bleed when brushing and/or flossing?

\_\_Aspirin \_\_ Pain or Popping of (TMJ) Jaw Joint?

\_\_Codeine **\_\_** Have you ever worn braces or false teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_**Food, Wine, Animal, Preservative**, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_ Sodas/Soft Drinks: Drinks for Day? \_\_\_\_

List any other drug allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Tobacco:** Packs per Day? \_\_\_\_\_\_\_\_ **Alcohol**: Drinks per Week?\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Coffee**: Cups Per Day?\_\_\_\_\_\_\_\_\_\_\_ **Tea**: Cups Per Day?\_\_\_\_\_\_\_

How many times a WEEKdo you? **Brush** \_\_\_\_ **Floss** \_\_\_\_\_\_\_

Hospitalizations/Surgeries*: (Lists Dates & Why?):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications & dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To the best of my knowledge, the stated responses are correct and true. If there are any changes in the my health history,**

**I will inform the dentist at beginning of every appointment.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print:** Patient/Parent/Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** Patient/Parent/ Legal Guardian Date Witness