- ACID REFLUX, GERD or ULCER? _____ ☐ ☐

HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE:

- TMJ/TMD (TEMPOROMANDIBULAR JOINT DISORDER) OR CLICKING OF JAW? _____ ☐ ☐
- DIFFICULTY OPENING or MUSCLE SPASMS OF THE JAW? _____ ☐ ☐
- HEADACHES, SORE MUSCLES OF HEAD/NECK UPON WAKING/OTHER? _____ ☐ ☐
- DIFFICULTY BREATHING THROUGH NOSE? SLEEP APNEA, CPAP MACHINE? _____ ☐ ☐
- ANY PROLONGED BLEEDING FROM AN INJURY, TOOTH EXTRACTION, etc.? BRUISE EASILY? _____ ☐ ☐
- A REACTION FROM A LOCAL ANESTHETIC? _____ ☐ ☐
- EXPERIENCED ANY ILLNESS OR COMPLICATIONS FOLLOWING DENTAL TREATMENT OF ANY KIND? PLEASE EXPLAIN.

  _____ ☐ ☐
- ARE YOU OR HAVE YOU EVER TAKEN MEDICATION TO HELP PREVENT OSTEOPOROSIS, SUCH AS:
- CIRCLE: FOSAMAX ACTONEL BONIVA ZOMETA AREDIA or other BISPHOSPHONATES _____ ☐ ☐
- DO YOU HAVE A HISTORY OF CHEMICAL DEPENDENCY/DRUG ABUSE? _____ ☐ ☐
- DO YOU HAVE A HISTORY OF ALCOHOL DEPENDENCY? _____ ☐ ☐
- HAVE YOU BEEN HOSPITALIZED OR UNDER THE CARE OF A PHYSICIAN IN THE LAST YEAR? _____ ☐ ☐
- ANY MENTAL HEALTH PROBLEMS /ANXIETY/ DEPRESSION? _____ ☐ ☐
- DO YOU FEEL SAFE AT HOME? _____ ☐ ☐
- ARE YOU BEING PHYSICALLY and/or SEXUALLY ASSAULTED AT HOME? _____ ☐ ☐
- DO YOU WISH TO SPEAK TO THE DOCTOR PRIVATELY ABOUT ANYTHING? _____ ☐ ☐
- DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM I SHOULD KNOW ABOUT?

EXPLAIN _____ ☐ ☐

WOMEN: ARE YOU PREGNANT OR NURSING? _____ ☐ ☐

ARE YOU TAKING BIRTH CONTROL? _____ ☐ ☐

ALLERGIC TO ANY DRUGS, MEDICATIONS, etc.?

	YES	NO	NOTES
LOCAL ANESTHETIC			
PENICILLIN			
AMOXICILLIN			
OTHER ANTIBIOTICS			
SULFITES			
SULFA DRUGS			
ASPIRIN			
LATEX			
OTHER (LIST):			

LIST ALL MEDICATIONS/SUPPLEMENTS:

MEDICATION	DOSE	FREQUENCY	NOTES

PATIENT SIGNATURE: _____ DATE: _____

DOCTOR SIGNATURE: _____ DATE: _____