Dolby Family Dentistry

PATIENT NAME: ______________________________

BIRTH DATE: ________________________________

DATE: ____________________

Name of Your Physician: ______________________________ Office Telephone: ____

Address of Your Physician: ____

1. Have you ever been hospitalized, had any major operations or had any serious illnesses? Yes No

   If yes, explain:

   ____

   ____

2. Have you been under a physician's care in the last 2 years? Yes No

   If yes, explain:

   ____

   ____

3. With regard to cigarette smoking, how would you classify yourself? Current smoker Ex-smoker Never smoker

4. Do you currently use smokeless tobacco (e.g. snuff, plug)? Yes No
   If yes, about how many times do you use smokeless tobacco per day? Less than 1 1-5 6-10 11-20 more than 20

5. Do you have (or have you ever been told you had) any of the following conditions? (circle all that apply)

   a. Congenital heart problems
   b. Infective endocarditis or other heart infection
   c. Artificial heart valves
   d. Heart Transplant
   e. Artificial joints or prostheses

6. Have you ever had an allergic reaction, or any other unusual reaction, to any of the following medications or substances?
   If yes, what reaction(s) did you have to this substance? (circle all that apply)

a.	Penicillin	Yes	No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)___________
b.	Sulfa or other antibiotics	Yes	No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)___________
c.	Aspirin	Yes	No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)___________
d.	Codeine or morphine	Yes	No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)___________
e.	Dental anesthetic (e.g. Novocain or lidocaine)	Yes	No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)___________
f.	Latex	Yes	No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)___________
g.	Airborne substances (e.g. pollen, perfume)	Yes	No	Rash	Swelling	Upset Stomach	Vomiting	Other reaction (explain)___________

   h. Other medications or substances (explain)____

7. Do you have (or have you ever been told you had) any of the following conditions?

a.	High blood pressure (hypertension)	Yes	No	Don't Know
b.	High cholesterol	Yes	No	Don't Know
c.	Heart disease (e.g., angina, coronary artery disease, congestive heart failure)	Yes	No	Don't Know
d.	Diabetes (sugar diabetes, blood sugar problems)	Yes	No	Don't Know
e.	Cancer or tumors	Yes	No	Don't Know
f.	Inflammatory diseases (e.g., arthritis, rheumatism, lupus, fibromyalgia)	Yes	No	Don't Know
g.	Frequent Headaches	Yes	No	Don't Know
h.	Asthma, emphysema, or other lung disease	Yes	No	Don't Know
i.	Thyroid problems	Yes	No	Don't Know
j.	Epilepsy or seizure disorders	Yes	No	Don't Know
k.	Fainting or dizzy spells	Yes	No	Don't Know
l.	Hepatitis or other liver disease	Yes	No	Don't Know
m.	Tuberculosis (TB)	Yes	No	Don't Know
n.	HIV+ or AIDS	Yes	No	Don't Know
o.	Blood disorders (e.g., anemia, hemophilia)	Yes	No	Don't Know
p.	Kidney problems	Yes	No	Don't Know
q.	Stomach or intestinal problems	Yes	No	Don't Know
r.	Phobias, severe anxieties, depression, or other psychological problems	Yes	No	Don't Know
s.	Radiation, surgery, or chemotherapy to treat cancer	Yes	No	Don't Know
t.	Bleed excessively after being cut or receiving dental care	Yes	No	Don't Know
u.	Heart attack, stroke, or coronary bypass operation	Yes	No	Don't Know
v.	Shortness of breath after climbing 1 flight of stairs	Yes	No	Don't Know
w.	Pacemaker	Yes	No	
x.	Pregnant or think you may be pregnant	Yes	No	
y.	Breastfeeding	Yes	No	
z.	Are there any other problems or issues about your health that you know of?	Yes	No	

If yes, explain____

____

8. Have you ever taken medications (such as bisphosphonates) that affect the bone or to prevent bone disease (e.g., Fosamax, Zometa, Actonel, Aredia)? Yes No

9. Are you currently taking any medications or substances, including over-the-counter, prescription, vitamin, or herbal products, for any reason? Please list below Yes No

Medications or substances (with dosage)

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____

____

____

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____

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I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical and dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM: Signature:________________________________ Date:____________________

If other than patient, indicate relationship to patient: ____