

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**MEDICAL HISTORY (CONT'D)**

7. Do you have or have you ever had asthma?
8. Do you have or have you ever had any heart or blood pressure problems?
9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
10. Do you have a prosthetic or artificial joint?
11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
12. Have you ever had hepatitis, jaundice or liver disease?
13. Do you have a bleeding problem or bleeding disorder?
14. Have you ever been hospitalized for any illnesses or operations?

If yes, please explain.

15. Do you have or have you ever had any of the following? Please check.

- |                                    |                                       |  |  |   |
|------------------------------------|---------------------------------------|--|--|---|
| <input type="checkbox"/> stroke    | <input type="checkbox"/> pacemaker    | <input type="checkbox"/> heart murmur    | <input type="checkbox"/> stomach ulcers      | <input type="checkbox"/> shortness of breath      |
| <input type="checkbox"/> cancer    | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> kidney disease  | <input type="checkbox"/> steroid therapy     | <input type="checkbox"/> mitral valve prolapse    |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> lung disease | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> chest pain, angina  | <input type="checkbox"/> drug/alcohol dependency  |
| <input type="checkbox"/> diabetes  | <input type="checkbox"/> heart attack | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> seizures (epilepsy) | <input type="checkbox"/> osteoporosis medications |

16. Are there any conditions or diseases not listed above that you have or have had?

If so, what?

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

18. Do you smoke or chew tobacco products?

19. Are you nervous during dental treatment?

20. **For women only:** Are you breastfeeding or pregnant?

If pregnant, what is the expected delivery date?

## DENTAL HISTORY

When was your last dental visit?

When did you last have dental x-rays?

How often do you brush your teeth?

How often do you floss your teeth?

Please ☒ YES or NO to each question.

1. Have you been seeing a dentist regularly?
2. Do any of your teeth ache?
3. Have you ever been advised to take antibiotics before dental appointments?
4. Do your gums bleed when you brush?
5. Do you have any pain when you chew?
6. Do you feel that you have bad breath?
7. Have you ever been in a vehicle accident or experienced any blows to your jaw?
8. Have you ever had any implant surgery in one or both of your jaws or jaw joints?

If you answered "yes," to the last question, who performed the surgery and when was it done?

Are you being followed up by a dental specialist?

Please list anything else not mentioned above regarding your past dental history.

**GENERAL RELEASE** (Please sign after completing medical questionnaire.)

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I had the opportunity to ask questions and receive answers to questions regarding my medical dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or any other health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X

(signature)

Patient ☐Parent ☐Guardian ☐

(print name of parent or guardian)

Reviewed by treating Dentist:

Date: