RENEW DENTAL

NAME OF PATIENT _____ DATE OF BIRTH _____

NAME OF PHYSICIAN _____ PHYSICIAN'S PHONE _____

PHYSICIAN ADDRESS _____

REASON FOR VISIT _____ DATE OF MOST RECENT VISIT TO PHYSICIAN _____

To ensure your well-being while undergoing treatment in our office, please answer the following questions with a YES or NO response and provide <u>further details</u> for all YES responses. All information will be considered confidential and for our records only.

Are you currently seeing a physician for treatment of a recent or ongoing medical condition? If yes, explain the condition.

YES NO ☐ ☐ _____

Have you been hospitalized within the last year? If yes, please explain:

YES NO ☐ ☐ _____

Have you ever had any serious medical trouble associated with any dental experience? If yes, please explain:

YES NO ☐ ☐ _____

Have you ever been advised to take antibiotics (like Penicillin, etc.) prior to a dental appointment? If yes, please explain:

YES NO ☐ ☐ _____

Do you have, OR have you had any of the following cardiovascular conditions? Please check all that apply:

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Coronary Bypass
- ☐ Angina
- ☐ Mitral Valve Prolapse
- ☐ Hardening of the Arteries
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Heart Murmur
- ☐ Shortness of Breath when lying down
- ☐ Chest Pain on Exertion
- ☐ Frequent or Unexpected Nose Bleeds
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Congestive Heart Failure
- ☐ Congenital Heart Defects
- ☐ Prosthetic Heart Valves
- ☐ Pacemaker: placement date: _____ Type: _____
- ☐ Surgically Implanted Defibrillator
- ☐ History of Infective Endocarditis
- ☐ Heart Transplant
- ☐ Shortness of Breath after Mild Exercise
- ☐ Swelling of the Ankles
- ☐ Abnormal Bleeding or Extended Clotting Time

Do you consider yourself to be under an abnormally high amount of stress?

YES NO ☐ ☐ _____

When was your last complete physical examination with your physician, including blood tests?

_____

Do you OR have you ever smoked?

YES NO ☐ ☐ How much? _____ When did you quit? _____

Do you use chewing tobacco?

YES NO ☐ ☐ How often? _____

Do you drink alcohol?

YES NO ☐ ☐ How much? _____

Do you have, OR have you had any of the following health conditions? Please check all that apply:

- ☐ Diabetes – Type: _____
- ☐ Artificial Joints – Which joints? _____
- ☐ Hepatitis – Which Type (A, B, or C)? _____
- ☐ Blood Transfusion – When? _____
- ☐ HIV
- ☐ Tuberculosis
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Asthma
- ☐ Autoimmune Disease – Which? _____
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Sinus Problems
- ☐ Cirrhosis
- ☐ Depression
- ☐ Drug/Alcohol Treatment
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Herpes
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Organ Transplant
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Radiation Treatment
- ☐ Severe Headaches
- ☐ Sexually Transmitted Disease
- ☐ Skin Conditions
- ☐ Ulcers

ALL

Are you **ALLERGIC** to **ANY** of the following?

- ☐ Penicillin
- ☐ Sulfa
- ☐ Local Dental Anesthetics
- ☐ Codeine
- ☐ Sedatives
- ☐ Aspirin
- ☐ Nickel
- ☐ Latex
- ☐ Sulfites
- ☐ Barbiturates
- ☐ Tranquilizers
- ☐ Tetracycline

WOMEN ONLY

Yes	No	
☐	☐	Are you pregnant? If so, expected delivery date? _____
☐	☐	Do you have regular gynecological checkups?
☐	☐	Have you reached menopause?
☐	☐	Are you taking hormone replacement?
☐	☐	Have you had a mammogram? Date: _____

Have you ever had an adverse reaction to **ANY** drug or medication? If yes, indicate medication and reaction:

YES NO

☐ ☐ _____

Do you have **ANY** disease, condition or medical problem **NOT LISTED** on this form? If yes, please indicate the condition:

YES NO

☐ ☐ _____

Please indicate if you are currently taking ANY of the following listed medications OR if you have taken any of these medications within the past year. Please check all that apply:

- ☐ Antibiotics
- ☐ Antidepressants (Prozac, Zoloft, Etc.)
- ☐ Antihistamines
- ☐ Blood Pressure Medication
- ☐ Blood Thinners
- ☐ Cortisone (Prednisone)
- ☐ Cholesterol Medication
- ☐ Decongestants
- ☐ Diuretics (water pills)
- ☐ Hormones (birth control, estrogen)
- ☐ Inhalants
- ☐ Insulin
- ☐ Heart Medication/Nitroglycerine
- ☐ Muscle Relaxants
- ☐ Pain Medication (Aspirin, Tylenol, Advil)
- ☐ Sleeping Pills
- ☐ Thyroid Medication
- ☐ Tranquilizers
- ☐ Vitamins

Please list your current medications OR attach a list of your medications to this form:

_____

_____

_____ _____

Patient Signature Date