

PREFERRED NAME _____	TODAY'S DATE _____	NAME	CLIENT
ADDRESS/POSTAL CODE _____	DATE OF BIRTH _____		
EMAIL _____	HOME PHONE _____		
EMERG. CONTACT/PHONE _____	CELL PHONE _____		
EMPLOYER _____	BUSINESS PHONE _____		
INSURANCE CO. _____	MEDICAL ALERT _____		

PHYSICIAN _____	OFFICE PHONE _____	DATE OF LAST EXAM _____	YES	NO	YES	NO	
1. Are you under medical treatment now?	<input type="checkbox"/>		<input type="checkbox"/>		5. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you under care of a medical specialist?					6. Do you use alcohol, cocaine or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been hospitalized for any surgical operation or serious illness?					7. Have you ever had any adverse or unusual reactions to any medications or injections, or any type of environmental or food allergy (i.e. penicillin's or other antibiotics, aspirin, codeine, local anaesthetic, latex)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?							
					8. WOMEN ONLY		
					a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
					b) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
					c) Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

9. CIRCLE Yes or No if you have or had any of the following Medical Condition(s), PLEASE EXPLAIN....			
1. Heart Attack Date: _____	Y/N	21. Kidney Disease _____	Y/N
2. High/Low Blood Pressure _____	Y/N	22. Liver Disease _____	Y/N
3. Heart Disease _____	Y/N	23. Asthma _____	Y/N
4. Angina _____	Y/N	24. Respiratory Problems _____	Y/N
5. Cardiac Arrhythmias _____	Y/N	25. Emphysema _____	Y/N
6. Heart Murmur _____	Y/N	26. Tuberculosis _____	Y/N
7. Cardiac Pacemaker _____	Y/N	27. Steroid Therapy _____	Y/N
8. Rheumatic Fever Date: _____	Y/N	Date: _____	
9. Swollen Ankles _____	Y/N	28. Hayfever/Environmental Allergies _____	Y/N
10. Easily Winded/Shortness of Breath _____	Y/N	29. Glaucoma _____	Y/N
11. Fainting During Dental Tx _____	Y/N	30. Rheumatoid/Osteo Arthritis _____	Y/N
12. Stroke Date & Type _____	Y/N	31. Joint Replacement or Implants _____	Y/N
13. Coumadin/Warafin _____	Y/N	Date: _____	
Dosage: _____		32. Chrons/Ulcerative Colitis _____	Y/N
Recent INR _____		33. Ulcers _____	Y/N
14. Anemia _____	Y/N	34. Epilepsy/Seizures _____	Y/N
15. Cancer Date & Type _____	Y/N	Any Auras _____	
Remission Date: _____		35. Sexually Transmitted Diseases _____	Y/N
16. Radiation/Chemotherapy _____	Y/N	36. Hepatitis/Jaundice Type: _____	Y/N
17. Leukemia _____	Y/N	37. AIDS/HIV _____	Y/N
18. Recent Weight Loss/Diet Therapy _____	Y/N	38. Any other Immune-Suppressant Conditions _____	Y/N
19. Diabetes Type: _____	Y/N	39. Clotting or Bleeding Disorders _____	Y/N
20. Thyroid Disease Type: _____	Y/N	40. Other _____	Y/N

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your test sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you had any orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head or neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had prolonged bleeding following extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Have you ever had instruction on the correct method of brushing your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Clicking? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever had instructions on the care of your gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain (joint, ear, side of face)? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| c) Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| d) Difficulty in chewing ? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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Risk Assessment	Brushing _____ Flossing _____	Rinsing _____ Adjuncts _____	Smoking _____ Stress _____	Diet _____ Other _____
<p>I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.</p> <p>SIGNATURE _____ X _____ YYYY/MM/DD Patient, Parent or Guardian</p>				

Update	CURRENT MEDICATIONS
Health Changes Dated: _____	1 _____
_____	2 _____
_____	3 _____
Hospitalization/Surgery(s): _____	4 _____

Physician's Name _____	Last Physical Exam _____
Physician's Phone _____	Allergies? _____
Patient Signature: _____	Staff Initials _____

Update	CURRENT MEDICATIONS
Health Changes Dated: _____	1 _____
_____	2 _____
_____	3 _____
Hospitalization/Surgery(s): _____	4 _____

Physician's Name _____	Last Physical Exam _____
Physician's Phone _____	Allergies? _____
Patient Signature: _____	Staff Initials _____

Update	CURRENT MEDICATIONS
Health Changes Dated: _____	1 _____

Hospitalization/Surgery(s): _____

2 _____
3 _____
4 _____

Physician's Name _____
Physician's Phone _____

Last Physical Exam _____

Allergies? _____

Patient Signature: _____ Staff Initials _____