Patient Name: Date of Birth:

Do you have a primary care physician? No ☐ Yes ☐ Primary Care Physician:

Location of Physician: Date of last exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your preferred pharmacy? (name & address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your sex? Male ☐ Female ☐

**Pregnancy History**

Are you pregnant? No ☐ Yes ☐ Are you nursing? No ☐ Yes ☐ Are you taking an oral contraceptive (birth control)? No ☐ Yes ☐

**Medical History**

Are you under the care of a specialist? No ☐ Yes ☐

Have you been hospitalized or have you had any surgeries? No ☐ Yes ☐

Do you have any disabilities? No ☐ Yes ☐

Have you ever taken bisphosphonate therapy (pills or injections for bone strengthening such as Fosamax, Boniva) for osteoporosis or cancer?

No ☐ Yes ☐

Please list all prescription and non-prescription medications you are taking, including herbal supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have bleeding problems or have ever had any prolonged bleeding following a surgical procedure? No ☐ Yes ☐

Do you have or have you ever had any of the following medical conditions/treatment: infective endocarditis, cardiac transplant, congenital heart deft/disease, prosthetic heart valve/patch/device, or cardiac valve repair? No ☐ Yes ☐

Has your doctor ever told you that you require antibiotic prophylaxis prior to dental procedures? No ☐ Yes ☐

Please select all that you are allergic to:

|  |  |  |  |
| --- | --- | --- | --- |
| Local Anesthesia (e.g. Lidocaine or Septocaine) | ☐ | Latex Rubber | ☐ |
| Penicillin/Amoxicillin | ☐ | Red Dye | ☐ |
| Other Antibiotics (including Sulfas) | ☐ | Any Metals (e.g. Nickel, Mercury, etc.) | ☐ |
| Sedatives | ☐ | Environmental/Seasonal | ☐ |
| Aspirin | ☐ | Other Allergies | ☐ |
| Codeine | ☐ | None | ☐ |
| Iodine | ☐ |  | ☐ |

Do you have, or have you had any of the following medical conditions? Select all that apply

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Acid Reflux | ☐ | Emphysema/COPD | ☐ | Leukemia | ☐ |
| ADHD | ☐ | Epilepsy/Convulsions/Seizures | ☐ | Liver Disease | ☐ |
| AIDS/HIV | ☐ | Fainting | ☐ | Osteoporosis | ☐ |
| Anemia | ☐ | Glaucoma | ☐ | Radiation Therapy | ☐ |
| Arthritis | ☐ | Hay Fever/Seasonal Allergies | ☐ | Recent Weight Loss | ☐ |
| Asthma | ☐ | Heart Attack | ☐ | Sexually Transmitted Disease | ☐ |
| Autism | ☐ | Heart Disease/Heart Failure | ☐ | Stomach/Intestinal Troubles | ☐ |
| Back/Neck Problems | ☐ | Heart Murmur | ☐ | Stroke | ☐ |
| Blood Clots | ☐ | Heart Surgery | ☐ | Swollen Ankles | ☐ |
| Cancer | ☐ | Hepatitis | ☐ | Thyroid Problems | ☐ |
| Cardiac Pacemaker | ☐ | Herpes Simplex Virus 1 | ☐ | Tuberculosis | ☐ |
| Chemo Therapy | ☐ | Jaundice | ☐ | Ulcers | ☐ |
| Chest Pains/Angina | ☐ | Joint Replacement or Implant | ☐ | Other | ☐ |
| Diabetes | ☐ | Kidney Disease | ☐ | Nove of the Above | ☐ |

**Smoking History**

Select the option that best describes your smoking status. Never☐ Daily ☐ Former ☐ Occasionally ☐

Select the smoking tobacco product type(s) you use or have used in the past. Cigarettes☐ Cigarillos ☐ Cigars ☐ Pipe ☐

Have you ever used any non-smoking tobacco products? No☐ Yes ☐

Select the non-smoking tobacco product type(s) you use or have used in the past. Chewing ☐ Snuff ☐ Smokeless ☐

How many cigarettes do you smoke per day? Less than 1 pack ☐ 1 pack/day ☐ 2 packs/day ☐

How old were you when you started smoking? (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_ How old were you when you quit smoking? (if applicable) \_\_\_\_\_\_\_\_\_

Please choose the option that best describes your current vaping status. Not a current user ☐ Current user ☐ I decline to answer ☐

At what age did you start vaping? (if applicable) \_\_\_\_\_\_\_\_\_

How frequently do you vape? Daily ☐ Occasionally ☐ Weekly ☐ Other ☐

If ‘other’ please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol/Drug History**

Do you have a history of substance use disorder or alcohol use disorder? No☐ Yes ☐ Do you currently drink alcohol? No☐ Yes ☐

How often do you drink alcohol? Never ☐ Daily ☐ Former ☐ Occasionally ☐

How many alcoholic drinks do you consume in a typical week? (7 full days and nights)

☐1-4/wk ☐15-21/wk

☐5-7/wk ☐22-28/wk

☐8-14/wk ☐>29/wk

Do you currently use drugs for recreational purposes? No☐ Yes ☐

Select the drugs you have taken for recreational purposes.

|  |  |  |  |
| --- | --- | --- | --- |
| None | ☐ | Marijuana | ☐ |
| Cocaine | ☐ | MDMA (Ecstasy) | ☐ |
| Heroin | ☐ | Methamphetamine | ☐ |
| Inhalants | ☐ | Opioids | ☐ |
| LSD | ☐ | Other/Not Listed | ☐ |

If ‘other/Not Listed’ please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

Have you been seen by a dentist before? No☐ Yes ☐

Name of previous dentist and location. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental exam. (month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your teeth sensitive to hot/cold foods or beverages? No☐ Yes ☐

Do you feel pain in any of your teeth? No☐ Yes ☐

Do you clench or grind your teeth? No☐ Yes ☐

Have you had any head, neck, or jaw injuries? No☐ Yes ☐