Honea Path Family Dentistry

Patient Name: Birth Date: Date Created:

DO YOU HAVE OR HAVE YOU EVER HAD?

Artifical heart valve/heart valve defect? What type?	Yes No	If yes	
History of infective endocarditis?	Yes No	If yes	
A Dr. advise you to take an antibiotic prior to dental treatment?	Yes No	If yes	
Congenital heart defect?	Yes No	If yes	
Total joint replacement? Please specify	Yes No	If yes	

Cardiovascular Disease?

Heart Attack	Yes No	Heart Trouble	Yes No	Heart Murmur	Yes No	Coronary Artery	Yes No
Disease	Yes No	Angina	Yes No	High Blood Pressure	Yes No	Stroke	Yes No
Palpitations	Yes No	Heart Surgery	Yes No	Pacemaker	Yes No		

Stint placed? If yes please explain when and why	Yes No	If yes	

Lung disease?

Asthma	Yes No	Emphysema	Yes No	COPD	Yes No	Chronic cough bronchitis	Yes No
Pneumonia	Yes No	Tuberculosis	Yes No	Shortness of Breath	Yes No	Chest Pain	Yes No
Severe Coughing	Yes No						

Liver Disease?

Jaundice	Yes No	Hepatitis	Yes No				

Kidney Disease?	Yes No		
Diabetes? If yes, what is your A1C?	Yes No	If yes	
Thyroid Issues/Removal of Thyroid/Hyperthyroidism? Please explain	Yes No	If yes	
Stomach Ulcers/Colitis? Please explain	Yes No	If yes	
Scleroderma?	Yes No		
Seizures, Convulsions, Epilepsy, Fainting or Dizziness? Please explain	Yes No	If yes	
Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion. Please explain	Yes No	If yes	
Arthritis (Osteo or Rheumatoid) Please explain	Yes No	If yes	
Osteoporosis?	Yes No		
HIV, AIDS, Hepatitis? Please explain	Yes No	If yes	
Any disease, drug or transplant operation that has depressed your immune system? Please explain	Yes No	If yes	

MEDICATIONS

Are you currently taking any medications?	Yes No		
Antibiotics? If yes, which medication and for what?	Yes No	If yes	
Blood Thinners (aspirin, plavix, coumadin, etc.)? If yes, which one and What is your INR?	Yes No	If yes	
Tylenol, Aleve or Ibuprofen? Which one and why?	Yes No	If yes	
Steroids (cortisone, prednisone, etc)? Which one and for what?	Yes No	If yes	
Insulin or oral Anti-Diabetic drugs? Please list	Yes No	If yes	
Heart Drugs (digitalis, inderal, nitroglycerin, etc)? Which ones and how often?	Yes No	If yes	
Other painkillers? Which one and for what?	Yes No	If yes	
Are you taking or HAVE YOU EVER TAKEN bisphosphonates for any of the following...	Yes No	If yes	

osteoporosis, myeloma, cancer or rheumatoid arthritis? (ex. reclast, fosamax, actonel, boniva, aredia, zometa) If yes, please explain

Are you taking any other medications....	Yes No	If yes	

including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals not already listed. If yes, please list

Are you taking illegal drugs? Please explain	Yes No	If yes	

DO YOU HAVE OR HAVE YOU EVER HAD?

Implants placed anywhere in your body?(heart valve, pacemaker, hip or knee) Please explain	Yes No	If yes
Radiation treatment for cancer? Please explain	Yes No	If yes
Clicking or popping of jaw joint? Pease explain	Yes No	If yes
Pain near ear, difficulty opening mouth, grind or clinch teeth, sleep apnea? Please explain	Yes No	If yes
Sinus/Nasal problems or Seasonal Allergies? Please	Yes No	If yes
Dry mouth?	Yes No	
Acid Reflux?	Yes No	
Difficulty chewing food?	Yes No	
Any past history of Alcohol/Chemical Dependency or Emotional Disorder that may affect your visit?	Yes No	If yes
Do you smoke or chew tobacco? If yes, how much?	Yes No	If yes
Do you have any other disease/condition/problem not listed above that we should know?	Yes No	If yes

ALLERGIES

Are you allergic to any of the following?

Local Anesthetics (Lidocaine, epinephrin	Yes No	Penicillin or other antibiotics	Yes No	Sedatives, barbituates	Yes No
Ibuprofen or Tylenol	Yes No	Codeine or orther pain killers	Yes No	Latex or Rubber products	Yes No
Metal of any kind, jewelry	Yes No	Other Allergies or reactions	Yes No	Chemicals/other materials previously used in the dental office	Yes No

FEMALES ONLY

For women only, please answer the following...

Are you pregnant or IS THERE ANY CHANCE	Yes No	Are you nursing?	Yes No	Are you using oral contraceptives	Yes No

If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness.

SIGNATURE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____