Although dental personnel primarily treat the area in and around your mouth, our mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **General**

Do you have a primary care provider?  Yes  No If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had any surgeries?  Yes  No If yes, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a head/neck injury?  Yes  No If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on a special diet?  Yes  No If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco?  Yes  No If yes, what type and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use controlled substances?  Yes  No If yes, what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take antibiotics before dental cleanings/procedures?  Yes  No

Do you have any history of periodontal disease?  Yes  No If yes, where and when was treatment provided? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Women Only**

Are you:

 Pregnant? If yes, what is your expected due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nursing?

Taking contraceptives? If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Allergies**

Are you allergic to any of the following?

Penicillin  Aspirin  Codeine  Acrylic  Metal  Latex  Sulfa Drugs  Local Anesthetics

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Conditions**

Do you have, or have you had, any of the following? Circle all that apply, and please provide details below.

**Artificial Joint**

**Artificial Heart Valve**

**Anaphylaxis**

**Heart Pacemaker**

**Mitral Valve Prolapse**

Acid Reflux

AIDS/HIV

Alzheimer’s Disease/Dementia

Asthma

Blood Disease

Blood Transfusion

Breathing Problems

Bruise Easily

Cancer

Chemotherapy/Radiation

Chest Pains

Cold Sores/Fever Blisters

Congenital Heart Disorder

Cortisone Medicine

Diabetes

Drug Addiction

Dry Mouth

Emphysema

Epilepsy/Seizures

Excessive Bleeding

Excessive Thirst

Fainting Spells/Dizziness

Frequent Cough

Frequent Diarrhea

Frequent Headaches

Glaucoma

Heart Attack/Failure

Heart Murmur

Heart Trouble/Disease

Hemophilia

Hepatitis A

Hepatitis B/C

High Blood Pressure

History of Alcoholism

History of Eating Disorders

Hives/Rash

Hypoglycemia

Irregular Heartbeat

Kidney Problems

Leukemia

Liver Disease

Low Blood Pressure

Lung Disease

Osteoporosis

Pain in Jaw Joints

Recent Weight Loss

Renal Dialysis

Shingles

Sickle Cell Disease

Sinus Trouble

Spina Bifida

Stomach/Intestinal Disease

Stroke

Swelling of Limbs

Thyroid Disease

Tuberculosis

Tumors/Growths

Ulcers

# **Medication**

Are you taking any medications, vitamins, supplements, pills, or drugs?  Yes  No If yes,

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Date started | For what reason? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you ever taken Phen-Fen or Redux?  Yes  No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken Boniva, Fosamax, Actonel, or any other medications containing bisphosphonates?  Yes  No If yes, which one and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 health. It is my responsibility to inform Bar Harbor Dental Group of any changes in medical status.

Signature of Patient or Parent/Guardian Date