

DO YOU HAVE:

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial (prosthetic) heart valve
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous infective endocarditis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Damaged valves in transplanted heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease (CHD)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unrepaired, cyanotic CHD
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repaired (completely) in last 6 months
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repaired CHD with residual defects

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any complications or difficulties with your prosthetic joint? If yes, specify _____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Allergies - Are you allergic to or have you had a reaction to: (Please fill out both columns)

To all Yes responses specify type of reaction.

Yes	No	Don't Know		Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, sedatives, or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food (Specify) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify) _____				

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion
			If yes, date _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/chemotherapy/radiation treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease
			If yes, specify below:
			<input type="radio"/> Angina
			<input type="radio"/> Arteriosclerosis
			<input type="radio"/> Congestive Heart Failure
			<input type="radio"/> Damaged heart valves
			<input type="radio"/> Heart attack
			<input type="radio"/> Heart murmur
			<input type="radio"/> High blood pressure
			<input type="radio"/> Low Blood Pressure
			<input type="radio"/> Mitral valve prolapse
			<input type="radio"/> Pacemaker
			<input type="radio"/> Rheumatic Fever
			<input type="radio"/> Rheumatic heart disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes. If yes, specify below:
			<input type="radio"/> Type I (Insulin dependent)
			<input type="radio"/> Type II
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder
			If yes, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. reflux
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections. Indicate type of infection _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders
			If yes, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines / severe headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders
			If yes, specify _____

Yes	No	Don't Know	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems.
			If yes, specify below:
			<input type="radio"/> Emphysema
			<input type="radio"/> Bronchitis, etc.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease, condition or problem not listed above that you think I should know about? Please explain:

Has a physician or other dentist recommended you take antibiotics prior to dental treatment?

If yes, what antibiotic and dose? _____

Name of physician or dentist making recommendation _____ **Phone** _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian _____ Date _____ Relationship to Patient _____

For Completion by Dentist / Auxiliary

Comments: _____

Signature of Dentist _____ Date _____