

MEDICAL INFORMATION Please check yes or no.

Do you wear contact lenses? _____

Do you use controlled substances (drugs) _____

Do you use tobacco (smoking, snuff, Chew, Bidis)? _____

If so, how interested are you in stopping? Circle one: Very / Somewhat / Not interested

Do you drink alcoholic beverages? _____ If yes, how much did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

Are you now under the care of a physician? _____ Physician Name _____

Has there been any change in your health within the past year? _____

If yes, please explain. _____

Have you had a serious illness, operation or been hospitalized in that past 2 years? _____

If yes, please explain? _____

Are you taking or have you recently taken any prescription or over the counter medicine? _____

If yes, please list all, including vitamins, natural or herbal preparation on/or dietary supplements: _____

Please check "yes" or "no" to indicate whether you have had or have any of the following conditions or diseases. If necessary explain yes answers below.

- | Yes | No | Yes | No | Yes | No | Yes | No |
|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> | <input type="checkbox"/> Angina | <input type="checkbox"/> | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> | <input type="checkbox"/> Damaged heart valve | <input type="checkbox"/> | <input type="checkbox"/> Heart attack | <input type="checkbox"/> | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> Heart murmur/MPV | <input type="checkbox"/> | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> | <input type="checkbox"/> Anemia/Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> | <input type="checkbox"/> Arthritis/Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> | <input type="checkbox"/> Lupus/Erythematosus | <input type="checkbox"/> | <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> Radiation | <input type="checkbox"/> | <input type="checkbox"/> Excessive urination |
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> | <input type="checkbox"/> Ulcer | <input type="checkbox"/> | <input type="checkbox"/> Gastrointestinal issues |
| <input type="checkbox"/> | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Seizure | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> | <input type="checkbox"/> Snoring/Sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> Swollen neck glands | <input type="checkbox"/> | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> | <input type="checkbox"/> Recurrent infections | <input type="checkbox"/> | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> | <input type="checkbox"/> Mental disorder | <input type="checkbox"/> | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> | <input type="checkbox"/> Weight loss/gain | | | | | | |

Do you have any disease, condition, or problem not listed above that you think your dentist should know about?

Please explain: _____

Reviewed by doctor: _____

Note: Both doctor and patient(s) 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 inquires 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 _____ Print Name _____ Date _____

Annual Update Form for Current Patients

Email:	Cell #:	Date
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As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked about responses to this questionnaire and there may be additional questions concerning your health. This information is vital and to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:	Home Phone: ()	Work Phone: ()
Address: <small>Mailing address</small>	City:	State:
Zip:		
Did your Dental insurance change? _____		

DENTAL INFORMATION

Has your dental health changed since your last visit? _____

Are you here for routine care? _____

Did you want to address a specific dental need today with your dentist? _____

MEDICAL INFORMATION

ALLERGIES: Please check "yes" or "no" to any allergies you have. To all yes responses please specify what you are allergic to type and severity of reaction. (Use the back of this form for additional space.)

<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; font-weight: normal;">Yes</th> <th style="text-align: left; font-weight: normal;">No</th> </tr> <tr> <td><input type="checkbox"/> Local Anesthetics</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Antibiotics</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hay fever/Seasonal</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Latex (rubber)</td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/> Antibiotics	<input type="checkbox"/>	<input type="checkbox"/> Hay fever/Seasonal	<input type="checkbox"/>	<input type="checkbox"/> Latex (rubber)	<input type="checkbox"/>	<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; font-weight: normal;">Yes</th> <th style="text-align: left; font-weight: normal;">No</th> </tr> <tr> <td><input type="checkbox"/> Sulfa Drugs</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Metal</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Animals</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/> Metal	<input type="checkbox"/>	<input type="checkbox"/> Animals	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>	<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; font-weight: normal;">Yes</th> <th style="text-align: left; font-weight: normal;">No</th> </tr> <tr> <td><input type="checkbox"/> Aspirin</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Iodine</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Food</td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	<input type="checkbox"/> Aspirin	<input type="checkbox"/>	<input type="checkbox"/> Iodine	<input type="checkbox"/>	<input type="checkbox"/> Food	<input type="checkbox"/>	<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; font-weight: normal;">Yes</th> <th style="text-align: left; font-weight: normal;">No</th> </tr> <tr> <td><input type="checkbox"/> Codeine or other narcotics</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Barbiturates</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Sedatives or sleeping pills</td> <td><input type="checkbox"/></td> </tr> </table>	Yes	No	<input type="checkbox"/> Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/> Barbiturates	<input type="checkbox"/>	<input type="checkbox"/> Sedatives or sleeping pills	<input type="checkbox"/>
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Do you or have you had Multiple myeloma or metastatic cancer? _____

Date Treatment began: _____

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? _____

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Bonivia, Reclast, Prolia) for osteoporosis or Paget's disease? _____

Since 2001, were you treated or are you presently scheduled to begin taking an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease? _____

Has a physician or previous dentists recommended that you take antibiotics prior to your dental treatment? _____

Name of physician or dentist making recommendation _____

Phone number: () _____

WOMEN ONLY: Are you pregnant? _____ Are you nursing? _____

Are you using birth control pills or hormone replacement therapy? _____