PATIENT NAME: **TODAY'S DATE:**

PHONE: **DATE OF BIRTH:**

Are you now under the care of a physician?_____ Physician's name & phone #: _____ _____ Are you in good health?_____ Has there been any health changes in the past 6 months?_____ If yes, please explain:_____ _____ _____	Have you had any serious illness, operation, or been hospitalized in the past 3 years?_____ If yes, please explain: _____ _____ Are you taking any prescription or over the counter medication? Please list:_____ _____ _____ _____ _____
Do you use tobacco?_____ If so, how interested are you in stopping?_____ Do you drink alcoholic beverages?_____ If yes, how much did you drink in the last 24 hours? _____ Do you use controlled substances (drugs)?_____	**Allergies:** Are you allergic to or had any reaction to any of the following, for any yes, please specify reaction: Local Anesthetic:_____ Codeine:_____ Aspirin:_____ Penicillin:_____ Other antibiotics:_____ Sedatives:_____ Sulfa Drugs:_____ Latex:_____ Metals:_____ Food:_____ Other:_____
Joint replacement: Have you had an orthopedic joint (hip, knee, shoulder, elbow, finger) replacement or any artificial plates, screws or rods? If yes, date and any complications? _____	**Women only:** Are you Pregnant?_____ Number of weeks?_____ Nursing?_____ Taking birth control or hormone replacement?_____
Have you ever taken or are taking an antiresorptive agent (Fosomax, Actonel, Atelvia, Boniva, Reclast, Prolia)?_____	Since 2001, have you ever taken or presently scheduled to begin treatment with an antiresorptive agent (Aredia, Zorneta, XGEVA)? _____

Please mark your response to indicate if you have or have not had any of the following conditions:

Y	N		Y	N		Y	N	
☐	☐	Artificial heart valve	☐	☐	HIV/AIDs infection	☐	☐	Glaucoma
☐	☐	Previous Infective Endocarditis	☐	☐	Arthritis	☐	☐	Hepatitis/Liver disease
☐	☐	Damaged valves in heart transplant	☐	☐	Autoimmune disease	☐	☐	Epilepsy
☐	☐	Congenital Heart Disease	☐	☐	Rheumatoid Arthritis	☐	☐	Fainting spells/seizures
☐	☐	Cardiovascular Disease	☐	☐	Systemic Lupus	☐	☐	Neurological disorders
☐	☐	Angina	☐	☐	Asthma			If yes_____
☐	☐	Arteriosclerosis	☐	☐	Bronchitis	☐	☐	Sleep disorders
☐	☐	Damaged Heart Valves	☐	☐	Emphysema	☐	☐	Mental health disorders
☐	☐	Heart Attack	☐	☐	Sinus trouble			If yes_____
☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐	Recurrent infections
☐	☐	Low Blood pressure	☐	☐	Chronic pain			If yes_____
☐	☐	High Blood pressure	☐	☐	Diabetes	☐	☐	Kidney disease
☐	☐	Mitral Valve prolapse	☐	☐	Eating disorder	☐	☐	Osteoporosis
☐	☐	Pacemaker	☐	☐	Gastrointestinal disease	☐	☐	Severe headaches
☐	☐	Rheumatic Fever	☐	☐	G.I Reflux/heartburn	☐	☐	Rapid weight loss/gain
☐	☐	Rheumatic heart disease	☐	☐	Ulcers	☐	☐	Sexually transmitted disease
☐	☐	Abnormal bleeding	☐	☐	Thyroid problems	☐	☐	Excessive Urination
☐	☐	Anemia	☐	☐	Stroke	☐	☐	Other_____
☐	☐	Blood transfusion						

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

Signature:_____ **Date:**_____

http://pocketdentistry.com/5-patient-assessment/