		DI	ENTAL PATIENT P	atient Name:	-		
					2		Form # 41009 rev: 03
tes:							
ient'	s signa	ature	Date	Signature, re	viewing	g doctor	Date
				ina accurately.	ı will irij	or m my c	ienusi oj any change in my
				and accurately	I will int	orm mu	lentist of any change in my
		No		or medical prob	lems NC	)T listed	on this form?
A	LL PA	TIENT	S:				Taking birth control pills?
					¥7	Ma	Tolsing high south 1 - 11.0
		No	Have you ever taken drugs for osteoporosis (Biph	nosphonates suc	ch as Fos	amax, A	ctonel, Zometa).
61. 62.	Yes Yes	No	Drugs, medications, over-the-counter medicines	64.	Yes	No	Tobacco in any form? Alcohol?
				12	¥7	NT-	Tohooo is see 6 0
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?
55. 54.	Yes	No	Prosthetic heart valve?	58. 59.	Yes	No	Pacemaker?
							Blood transfusions? Surgeries?
51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
DC	ο γου	HAVE	OR HAVE YOU HAD:				
39.	Yes	No			Yes	No	Diabetes?
37. 38.	Yes	No	Allergies to: drugs, foods, medications, latex?	48. 49.	Yes	No	Thyroid, adrenal disease?
							Herpes? Kidney, bladder disease?
<i>35</i> .	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
32. 33.	Yes	No		43. 44.	Yes	No	Skin diseases?
							Arthritis, rheumatism? Eye diseases?
<i>30</i> .	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
29.	Yes	No	Heart disease?	40.	Yes	No	HIV/AIDS
							1 2
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?
	Yes				Yes	No	Jaundice?
							Frequent urination? Dry mouth?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
11. 12.	Yes	No	Bleeding problems, bruising easily?	22. 23.	Yes	No	Seizures?
							Fainting spells? Blurred vision?
<i>9</i> .	Yes	No	Shortness of breath?	<i>20.</i>	Yes	No	Headaches?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
				ut?			
~	V	NT-	Date of last medical exam:		of last De	ental exam	n:
4.	Yes	No					
	103	INO	Have you been hospitalized or had a serious illnes If YES, why?	ss in the last thr	ee years:		
3.	Yes	No	The second	and the share have all and			
	5. 6. CI 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. DC 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. DC 51. 52. 53. 54. 55. AI 61. 62b. WW 65. AI fso, iche be iche che che che che che che che che che	5. Yes 6. Yes CIRCLE 7. Yes 8. Yes 9. Yes 10. Yes 11. Yes 12. Yes 13. Yes 14. Yes 15. Yes 16. Yes 17. Yes 10. Yes 30. Yes 31. Yes 32. Yes 33. Yes 34. Yes 35. Yes 36. Yes 37. Yes 38. Yes 39. Yes 39. Yes 39. Yes 39. Yes 30. Yes 37. Yes 38. Yes 39. Yes 39. Yes 30. Yes 31. Yes 32. Yes 33. Yes 34. Yes 35. Yes 36. Yes 37. Yes 38. Yes 39. Yes 37. Yes 38. Yes 39. Yes 30. Yes 30. Yes 31. Yes 32. Yes 33. Yes 34. Yes 35. Yes 36. Yes 37. Yes 38. Yes 39. Yes 52. Yes 53. Yes 53. Yes 54. Yes 55. Yes 62. Yes 56. Yes 67. Yes 67. Yes 58. Signa 67. Yes 59. Yes 50. Yes 50. Yes 51. Yes 52. Yes 53. Yes 54. Yes 55. Yes 55. Yes 56. Yes 56. Yes 57. Yes	5. Yes No 6. Yes No CIRCLE APPR 7. Yes No 8. Yes No 9. Yes No 10. Yes No 11. Yes No 12. Yes No 13. Yes No 14. Yes No 15. Yes No 16. Yes No 17. Yes No 17. Yes No 10. Yes No 30. Yes No 31. Yes No 32. Yes No 33. Yes No 34. Yes No 35. Yes No 35. Yes No 36. Yes No 37. Yes No 38. Yes No 39. Yes No 39. Yes No 39. Yes No 51. Yes No 52. Yes No 53. Yes No 53. Yes No 53. Yes No 54. Yes No 55. Yes No 55. Yes No 55. Yes No 56. Yes No 56. Yes No 57. Yes No	Date of last medical exam: 5. Yes No Have you had problems with prior dental treatmen 6. Yes No Are you in pain now? CIRCLE APPROPRIATE ANSWERS 7. Yes No Chest pain (angina)? 8. Yes No Sollen ankles? 9. Yes No Shortness of breath? 10. Yes No Recent weight loss, fever, night sweats? 11. Yes No Persistent cough, coughing up blood? 12. Yes No Bleeding problems, bruising easily? 13. Yes No Biteding problems, bruising easily? 13. Yes No Difficulty swallowing? 15. Yes No Difficulty swallowing? 16. Yes No Difficulty swallowing? 17. Yes No Difficulty urinating, blood in stools? 16. Yes No Difficulty urinating, blood in urine? DOYOU HAVE OR HAVE YOU HADE 19. Yes No Heart disease? 30. Yes No Heart disease? 31. Yes No Heart disease? 32. Yes No Rheumatic fever? 33. Yes No Stroke, hardening of arteries? 34. Yes No Stroke, hardening of atteries? 35. Yes No Asthma, TB, emphysema, other lung diseases? 36. Yes No Heartitis, other liver disease? 37. Yes No Asthma, TB, emphysema, other lung diseases? 38. Yes No Allergies to: drugs, foods, medications, latex? 39. Yes No Radiation treatments? 31. Yes No Parily history of diabetes, heart problems, turnor DOYOU HAVE OR HAVE YOU HADE 51. Yes No Antificial joint? ARE YOU TAKING: 61. Yes No Recreational drugs? 62. Yes No Artificial joint? ARE YOU TAKING: 61. Yes No Are you or could you be pregnant or nursing? ALL PATIENTS: 67. Yes No Do you have or have you had any other diseases of the past of my knowledge, I have answered every question completely of the and/or medication.	Date of last medical exam:       Date of         5. Yes       No       Have you had problems with prior dental treatment?         6. Yes       No       Are you in pain now?         CIRCLE APPROPRIATE ANSWERS         7. Yes       No       Chest pain (angina)?       18.         8. Yes       No       Shortness of breath?       20.         10. Yes       No       Recent weight loss, fever, night sweats?       21.         11. Yes       No       Bleeding problems, bruising easily?       23.         13. Yes       No       Difficulty swallowing?       25.         14. Yes       No       Difficulty swallowing?       25.         15. Yes       No       Diarthea, constipation, blood in stools?       26.         16. Yes       No       Frequent vomiting, nausea?       27.         17. Yes       No       Heart disease?       40.         20. You HAVE OR HAVE YOU HAD:       29.       Yes       No       Heart murmurs?       42.         21. Yes       No       Heart disease?       40.       33.       Yes       No       Heart disease?       40.         30. Yes       No       Heart disease?       41.       31.       Yes       No       Heart disease? <td>Date of last medical exam:       Date of last Defines with prior dental treatment?         6. Yes       No       Are you in pain now?         CIRCLE APPROPRIATE ANSWERS         7. Yes       No       Schemankles?       18. Yes         8. Yes       No       Schemankles?       20. Yes         9. Yes       No       Schemankles?       21. Yes         10. Yes       No       Persistent cough, coughing up blood?       22. Yes         13. Yes       No       Persistent cough, coughing up blood?       23. Yes         14. Yes       No       Persistent cough, coughing up blood?       25. Yes         15. Yes       No       Diafteaulty swallowing?       26. Yes         16. Yes       No       Diafteaulty urinating, blood in stools?       26. Yes         17. Yes       No       Difficulty urinating, blood in urine?       28. Yes         19. Yes       No       Heart disease?       40. Yes         20. You HAVE OR HAVE YOU HAD:       29.       Yes       No       Heart disease?       41. Yes         21. Yes       No       Heart disease?       40. Yes       31. Yes       No       Stock, heart disease?       47. Yes         32. Yes       No       Rheart disease?       47. Yes</td> <td>Date of last medical exam:      </td>	Date of last medical exam:       Date of last Defines with prior dental treatment?         6. Yes       No       Are you in pain now?         CIRCLE APPROPRIATE ANSWERS         7. Yes       No       Schemankles?       18. Yes         8. Yes       No       Schemankles?       20. Yes         9. Yes       No       Schemankles?       21. Yes         10. Yes       No       Persistent cough, coughing up blood?       22. Yes         13. Yes       No       Persistent cough, coughing up blood?       23. Yes         14. Yes       No       Persistent cough, coughing up blood?       25. Yes         15. Yes       No       Diafteaulty swallowing?       26. Yes         16. Yes       No       Diafteaulty urinating, blood in stools?       26. Yes         17. Yes       No       Difficulty urinating, blood in urine?       28. Yes         19. Yes       No       Heart disease?       40. Yes         20. You HAVE OR HAVE YOU HAD:       29.       Yes       No       Heart disease?       41. Yes         21. Yes       No       Heart disease?       40. Yes       31. Yes       No       Stock, heart disease?       47. Yes         32. Yes       No       Rheart disease?       47. Yes	Date of last medical exam: