Westdale Dental, PC

Patient: _____ **Birth date:** ____/____/_____ **Age:**____ **Today's date:** ____/____/_____

Your current physical health is: Good Fair Poor **Physician's (Medical Doctor) Name:** _____

Please list any prescription, over-the-counter medicines, herbal or dietary supplements currently being taken and for what conditions:

_____ to treat _____ _____ to treat _____

_____ to treat _____ _____ to treat _____

_____ to treat _____ _____ to treat _____

Have you ever had or are currently experiencing any of the following diseases or medical conditions? (check all that apply)

- ☐ Pacemaker
- ☐ Heart Attack/Stroke
- ☐ High Blood Pressure
- ☐ Use/Carry Nitroglycerin
- ☐ Endocarditis (heart infection)
- ☐ Congenital Heart Defects (from birth)
- ☐ Heart Bypass or Stent
- ☐ Artificial Heart Valve
- ☐ Angina (chest pain)
- ☐ Daily Aspirin Reg.____ Baby ____
- ☐ Blood Thinners (Coumadin,Plavix,etc)
- ☐ Anemia/Leukemia
- ☐ Acid Reflux/Heartburn/GERD
- ☐ Cancer Type_____ Date ____
- ☐ Radiation/Chemotherapy
- ☐ Diabetes Type_____
- ☐ Insulin Dependent
- ☐ Bisphosphonates (Boniva,Fosamax,etc)
- ☐ Osteoporosis
- ☐ Kidney concerns
- ☐ Thyroid disorder/concern
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ HIV or AIDS
- ☐ Sinus Concerns
- ☐ Seasonal Allergies/Hay Fever
- ☐ Asthma/ needs Inhaler
- ☐ Eating Disorder(s)
- ☐ Rheumatoid Arthritis
- ☐ Fainting
- ☐ Bleeding Disorder
- ☐ Difficulty Hearing
- ☐ Alcoholism/Drug abuse
- ☐ Recreational drugs
- ☐ Artificial Joints (hip,knee,etc)
  Date_____ Type_____
  Date _____Type_____
  Date _____Type_____
- ☐ Pregnant or nursing
- ☐ Use tobacco products (smoke/chew)
  Are you interested in quitting? Y N
- ☐ Anxiety/Depression
- ☐ Epilepsy or Seizure
- ☐ Lupus/Celiac/Auto-immune concern

Please list hospitalizations (surgeries, emergency room) within the last year: _____

Do you require any special accommodations? :

_____

Are you allergic to any of the following? If so, indicate what kind of reaction you had:

- ☐ Foods_____
- ☐ Latex _____
- ☐ Metals or Dental Materials _____
- ☐ Other _____
- ☐ Local Anesthetics _____
- ☐ Medicines (penicillin, Sulfa, etc) _____
- ☐ Do you have an epi pen _____

Dental Issues. Please indicate if you wish to discuss treatment of the following:

Areas of pain or sensitivity	Straightness of teeth	Bleeding of gums	Clicking or popping jaw
Bad Breath	Whiteness of teeth	Alternatives for existing dental work	Sores or growths in mouth
Clenching or grinding of teeth	Sleep apnea		

Have you been told you need antibiotics before dental treatment? Y N Reason _____
Is there anything not listed that you think we should know about you? _____

_____

I acknowledge that I have answered the above questions correctly and to the best of my ability. All my questions regarding this form have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of person completing form

Relationship if other than patient