

LEWIS DENTAL GROUP

• Are you currently under a physician's care; been recently hospitalized or had a head/neck injury?

No If yes:

• Have you ever taken Fosamax, Boniva, Actonel, or any medication containing bisphosphonates?

No If yes:

• Are you required to take antibiotic premedication for dental procedures?

No If yes:

• Do you use controlled substances? Yes No

• Have you ever had a sleep study? Yes No

• Do you use marijuana (cannabis)? Yes No

• Do you use a CPAP machine? Yes No

• Do you use tobacco? Yes No

• Have you had any orthodontic treatment? Yes No

• Do you like your smile? Yes No

Women: Are you pregnant/trying to get pregnant? Yes No Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

Are you allergic to any of the following?

- Acetaminophen Acrylic Aspirin Codeine Erythromycin Ibuprofen Latex Penicillin
 Local Anesthetics Metal Pine Nuts Sulfa Drugs None Other:

Please list all medications and supplements you are currently taking, including blood thinners:

Health Conditions: Do you have, or have you had any of the following?

- | | | | |
|-------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Addiction/Alcoholism | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy or Seizure | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Frequent Cough |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Heart Trouble/Disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Ulcers |
| | | | <input type="checkbox"/> None |

Physician _____ Last Exam Date _____

Previous Dentist _____ Last Exam Date _____

Have you ever had an illness not listed? No If yes:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature X _____ Date _____