DENTAL SURGEONS & IMPLANT CENTERS OF FALL RIVER AND DARTMOUTH

Patient Name:_____**Date**_____/____/_____ **Age**_____

Dentist_____**Primary Physcian**_____**PCP Tel#( )**_____ **Last Visit**____/_____/____

HAVE YOU EVER HAD OR HAVE YOU NOW: (*Please check at the RIGHT of **each** item*)

CHECK EACH ITEM (Use ink only)	YES	NO	DON'T KNOW	CHECK EACH ITEM (Use ink only)	YES	NO	DON'T KNOW	CHECK EACH ITEM (Use ink only)	YES	NO	DON'T KNOW
Epilepsy or Seizures				Hemophilia				Ulcers/Reflux			
Fainting or Dizziness				Bruise or bleed easily				Kidney problems			
Nervousness				Heart problems or Angina				Venereal disease			
Stroke				Hypertension (high BP)				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold Sores (Herpes)				Heart Murmur				Arthritis			
Persistent Cough				Mitral valve prolapse				Painful joints			
Emphysema				Congenital heart lesion				Prosthetic joint(s)			
Tuberculosis/ PPD positive				Heart surgery				Hives			
Asthma				Prosthetic heart valve(s)				Steroid medication(s)			
Hay Fever				Pacemaker				Anxiety/Depression			
Sinus problems				Blood transfusion(s)				Alcoholism/Drug Addiction			
Anemia				Liver disease				Significant weight gain/loss			
Sickle cell disease				Hepatitis type:_____				Cancer/ Radiation treatment			
Chest Pain				Sleep Apnea				TMJ Problems			
Ankle swelling				Difficulty with anesthesia				Osteoporosis			
Birth control medication(s)				**Pregnant** _____ **Yes** _____ **No** **Estimated Delivery** _____							

Be aware that some medications can decrease the effectiveness of birth control pills.

1. DO YOU REQUIRE PRE-MEDICATION WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT FOR RHEUMATIC FEVER, HEART VALVE, JOINT REPLACEMENT OR KIDNEY DIALYSIS? _____ YES _____ NO

2a. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? If yes, please describe:

2b. ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO REASON?

3. DO YOU HAVE ANY **ALLERGIES**? IF YES, PLEASE LIST: (INCLUDING MEDICATIONS OR LATEX)

4. HAVE YOU HAD ANY SURGERIES OR HOSPITALIZATIONS? If yes, please list and date:

5. PLEASE LIST ANY MEDICATIONS & DOSAGES YOU TAKE ON A REGULAR BASIS: (INCLUDING HERBAL SUPPLEMENTS OR ASPIRIN)

6. DO YOU SMOKE OR CHEW TOBACCO? Yes_____ No_____ How much? How many years?

7. DO YOU USE STREET DRUGS INCLUDING MARIJUANA? Yes_____ No _____ How much? How many years?

8. DO YOU USE ALCOHOL? Yes _____ No _____ What do you use? How Frequently?

9. IS THERE ANYTHING YOU WISH TO DISCUSS PRIVATELY WITH THE DOCTOR? _____YES _____ NO

I certify that I have read & understand the above. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Please sign & date below: ***Patient*** ***(Parent or guardian if minor)***	Any change since last visit?	**Reviewing doctor's signature & date:**
X _____ **Date**		_____ Date _____
X _____ Date_____	___YES ___NO	_____ Date _____