

Information Update

Have you had a change in your health since your last visit?

Heart (surgery, disease, attack)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hepatitis, any form	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart murmur (mitral valve prolapse)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Joint replacement	<input type="checkbox"/> No	<input type="checkbox"/> Yes	HIV Infection/AIDS	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Taken Fen-phen or other diet pills	<input type="checkbox"/> No	<input type="checkbox"/> Yes			

Have you had a visit to a physician since your last dental visit? No Yes

Women: Are you pregnant? No Yes Are you a nursing mother? No Yes

Are you taking any herbal supplement/medications? No Yes

If yes, which ones? _____

Diet: Restricted Diet _____

How many meals a day _____

Food Allergies _____

Sugar in your diet: None Slight Moderate High

Please list any medications you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Do you have any allergies? No Yes List: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (*print name*)

Patient Signature

Date

Doctor (*print name*)

Doctor Signature

Date

Doctors use only:

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental Management Considerations:
