

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant? No Yes
 If no, are you planning a pregnancy in the near future? No Yes
 Are you a nursing mother? No Yes
 Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
 Have you ever received a diagnosis of "high blood pressure"? No Yes
 What is your normal blood pressure? S /D Today: _____ / _____

Are you allergic or have you had a reaction to:

- a. Local anesthetics No Yes
- b. Penicillin or other antibiotics No Yes
- c. Aspirin, Ibuprofen or Tylenol No Yes
- d. Codeine, Valium® or other sedatives No Yes
- e. Latex or Metals No Yes
- f. Other (please specify) _____ No Yes

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day?	For how long?	No	Yes
Do you want to quit using tobacco?		No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?		No	Yes
Do you use any mood altering drugs other than those previously listed?		No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies

Sugar in your diet (circle one): *none slight moderate high*

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

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