

PRIES DENTAL CARE

general, family & cosmetic dentistry



CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
If yes, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
Date of last medical exam? _____ Date of last dental exam? _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

HAVE YOU EXPERIENCED:

- | | |
|---|-----------------------------------|
| 7. Yes No Chest Pain (angina)? | 18. Yes No Dizziness? |
| 8. Yes No Swollen ankles? | 19. Yes No Ringing in ears? |
| 9. Yes No Shortness of breath? | 20. Yes No Headaches? |
| 10. Yes No Recent weight loss, fever, night sweats? | 21. Yes No Fainting spells? |
| 11. Yes No Persistent cough, coughing up blood? | 22. Yes No Blurred vision? |
| 12. Yes No Bleeding problems, bruising easily? | 23. Yes No Seizures? |
| 13. Yes No Sinus problems? | 24. Yes No Excessive thirst? |
| 14. Yes No Difficulty swallowing? | 25. Yes No Frequent urination? |
| 15. Yes No Diarrhea, constipation, blood in stools? | 26. Yes No Dry mouth? |
| 16. Yes No Frequent vomiting, nausea? | 27. Yes No Jaundice? |
| 17. Yes No Difficulty urinating, blood in urine? | 28. Yes No Joint pain, stiffness? |

DO YOU HAVE OR HAVE YOU HAD:

- | | |
|--|--|
| 29. Yes No Heart disease? | 45. Yes No Anemia? |
| 30. Yes No Heart attack, heart defects? | 46. Yes No VD (Syphilis or Gonorrhea)? |
| 31. Yes No Heart murmurs? | 47. Yes No Herpes? |
| 32. Yes No Rheumatic fever? | 48. Yes No Kidney, bladder disease? |
| 33. Yes No Stroke, hardening of arteries? | 49. Yes No Thyroid, adrenal disease? |
| 34. Yes No High blood pressure? | 50. Yes No Diabetes? |
| 35. Yes No Asthma, TB, emphysema, other lung diseases? | 51. Yes No Psychiatric care? |
| 36. Yes No Hepatitis, other liver disease? | 52. Yes No Radiation treatments? |
| 37. Yes No Stomach problems, ulcers? | 53. Yes No Chemotherapy? |
| 38. Yes No Allergies to: drugs, foods, medications, latex? _____ | 54. Yes No Prosthetic heart valve? |
| 39. Yes No Family history of diabetes, heart problems, tumors? | 55. Yes No Artificial joint? |
| 40. Yes No AIDS | 56. Yes No Hospitalization? |
| 41. Yes No Tumors, cancer? | 57. Yes No Blood transfusions? |
| 42. Yes No Arthritis, rheumatism? | 58. Yes No Surgeries? |
| 43. Yes No Eye diseases? | 59. Yes No Pacemaker? |
| 44. Yes No Skin diseases? | 60. Yes No Contact lenses? |

ARE YOU TAKING?

- | | |
|---|---------------------------------|
| 61. Yes No Recreational Drugs? | 63. Yes No Tobacco in any form? |
| 62. Yes No Drugs, medications, over-the-counter medicines? (including Aspirin), natural remedies? | 64. Yes No Alcohol? |

Please list: _____

WOMEN ONLY:

- | | |
|--|--|
| 65. Yes No Are you or could you be pregnant? | 66. Yes No Taking birth control pills? |
|--|--|

ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

68. Yes No Have you ever had exposure to bisphosphonates? Ex: Fosamax, (aldronate), actonel (rise dronate) Boniva (ibandronate)?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ Date: _____

Dr's signature: _____ Date: _____

