

Correct answers to the following questions will allow your dentist and hygienist to treat you on an individual basis, providing care which is appropriate for your particular needs.

1. Why are you now seeking dental treatment? \_\_\_\_\_
2. Are you now under the care of a physician? \_\_\_\_\_  
 If so, what is the condition being treated? \_\_\_\_\_
3. Have you ever had excessive bleeding after an extraction, or do cuts take longer to heal than previously? \_\_\_\_\_ Yes No
4. (Women) Are you pregnant? If so, give due date \_\_\_\_\_ Yes No
5. Do you use tobacco in any form? If yes, how much? \_\_\_\_\_ Yes No
6. Have you been told you need to premedicate for dental work? \_\_\_\_\_ Yes No
7. Do you have, or have you ever had, any of the following? Please circle Yes or No.

**GENERAL HEALTH**

Tire easily/ weakness \_\_\_\_\_ Yes No  
 Persistent fever \_\_\_\_\_ Yes No

**SKIN**

Eruptions (rash), hives \_\_\_\_\_ Yes No

**EYES**

Glaucoma \_\_\_\_\_ Yes No

**EARS/NOSE/THROAT**

Loss of hearing \_\_\_\_\_ Yes No  
 Ringing in ears \_\_\_\_\_ Yes No  
 Frequent nose bleeds \_\_\_\_\_ Yes No  
 Sinus problems \_\_\_\_\_ Yes No  
 Soreness/hoarseness \_\_\_\_\_ Yes No

**ENDOCRINE**

Diabetes \_\_\_\_\_ Yes No  
 Family history of diabetes \_\_\_\_\_ Yes No  
 Thyroid condition/goiter \_\_\_\_\_ Yes No  
 Other \_\_\_\_\_ Yes No

**NERVOUS SYSTEM**

Stroke \_\_\_\_\_ Yes No  
 Headaches \_\_\_\_\_ Yes No  
 Convulsions/epilepsy \_\_\_\_\_ Yes No  
 Numbness/tingling \_\_\_\_\_ Yes No  
 Psychiatric treatment \_\_\_\_\_ Yes No  
 Dizziness/fainting \_\_\_\_\_ Yes No

**RESPIRATORY**

Tuberculosis \_\_\_\_\_ Yes No  
 Emphysema \_\_\_\_\_ Yes No  
 Asthma/hay fever \_\_\_\_\_ Yes No  
 Persistent cough \_\_\_\_\_ Yes No  
 Sputum production (phlegm) \_\_\_\_\_ Yes No  
 Difficulty breathing while lying down \_\_\_\_\_ Yes No

**OTHER**

Radiation/Chemotherapy \_\_\_\_\_ Yes No  
 Artificial Joints \_\_\_\_\_ Yes No  
 Tumors/growths \_\_\_\_\_ Yes No

**HEART/BLOOD VESSELS**

Rheumatic fever \_\_\_\_\_ Yes No  
 Heart murmur \_\_\_\_\_ Yes No  
 Chest pain/discomfort \_\_\_\_\_ Yes No  
 Heart attack/heart trouble \_\_\_\_\_ Yes No  
 Shortness of breath \_\_\_\_\_ Yes No  
 Swelling of ankles \_\_\_\_\_ Yes No  
 High blood pressure \_\_\_\_\_ Yes No  
 Congenital heart disease \_\_\_\_\_ Yes No  
 Mitral valve prolapse \_\_\_\_\_ Yes No  
 Artificial heart valve \_\_\_\_\_ Yes No  
 Pacemaker \_\_\_\_\_ Yes No  
 Heart surgery \_\_\_\_\_ Yes No  
 Other \_\_\_\_\_ Yes No

**OTHER**

Cancer \_\_\_\_\_ Yes No  
 HIV+/AIDS \_\_\_\_\_ Yes No  
 Hepatitis \_\_\_\_\_ Yes No

8. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetic (e.g. Novocaine) _____	Yes	No	Aspirin or codeine _____	Yes	No
Barbiturates/sedatives/sleeping pills _____	Yes	No	Sulfa drugs _____	Yes	No
Penicillin _____	Yes	No	Other allergies _____	Yes	No
Other antibiotics _____	Yes	No			

9. Are you taking any of the following?

Antibiotics/sulfa drugs _____	Yes	No	Tranquilizers _____	Yes	No
Blood thinners _____	Yes	No	Insulin/other diabetes drugs _____	Yes	No
Blood pressure medication _____	Yes	No	Digitalis/other heart medications _____	Yes	No
Thyroid medication _____	Yes	No	Nitroglycerin _____	Yes	No
Cortisone/steroids _____	Yes	No	Aspirin _____	Yes	No
Antihistamines/allergy drugs/cold medicine _____	Yes	No	Other medication _____	Yes	No

If you answer "yes" to any of the above under #8 and #9, list **name** of medication and **dosage (if appropriate)** below:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

10. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? \_\_\_\_\_  
\_\_\_\_\_

11. Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

12. Have you ever had any serious trouble associated with previous dental treatment? \_\_\_\_\_  
\_\_\_\_\_

13. Does dental treatment make you nervous? No \_\_\_\_\_ Slightly \_\_\_\_\_ Moderately \_\_\_\_\_ Extremely \_\_\_\_\_

14. Date of last dental visit \_\_\_\_\_ Name of dentist \_\_\_\_\_

15. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? \_\_\_\_\_

If so, when? \_\_\_\_\_

**To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or change in my medication, I will inform the dentist at my next appointment.**

**Signature of Patient,  
Parent or Guardian  
(required)** \_\_\_\_\_

**Date** \_\_\_\_\_

**Print Name** \_\_\_\_\_

***THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM ACCURATELY!***

**BEACHCREST DENTAL, INC.  
88 BEACH STREET  
WESTERLY, RI 02891  
401-596-0075**