Time 10:42 AM

Yahara Dental, S.C
2017

Date 2/1/2018

Patient Name:

Birth Date:

Date Created:

Questions

General practitioner's name and phone #:	☐	If yes
Cardiologist or Orthopedic doctor's name and phone	☐	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head/neck injury?	◯ Yes ◯ No	If yes
Are you currently taking any medications or pills?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes
Have you ever had to pre-medicate before dental treatment?	◯ Yes ◯ No	If yes
Have you ever had blood clotting problems?	◯ Yes ◯ No	If yes
Are you taking/have you ever taken medication for Osteoporosis?	◯ Yes ◯ No	If yes

Do you have/have you had any of the following:

☐ Aids/HIV Positive	☐ Alzheimer's Disease	☐ Anaphylaxis	☐ Artificial Heart Valve
☐ Artificial Joints	☐ Asthma	☐ Cancer	☐ Chemotherapy
☐ Cold Sores/Fever Blisters	☐ Diabetes	☐ Drug Addiction	☐ Emphysema
☐ Epilepsy/Seizures	☐ Excessive Bleeding	☐ Faiting Spells/Dizziness	☐ Frequent Headaches
☐ Heart Attack/Failure	☐ Heart Murmur	☐ Heart Pace Maker	☐ Hemophilia
☐ Hepatitis A	☐ Hepatitis B or C	☐ Herpes	☐ High Blood Pressure
☐ High Cholesterol	☐ Hypoglycemia	☐ Kidney Problems	☐ Liver Disease
☐ Mitral Valve Prolapse	☐ Organ Transplant	☐ Pain in Jaw Joints	☐ Radiation Treatment
☐ Renal Dialysis	☐ Stroke		

Any other serious illness or surgery not listed ◯ Yes ◯ No If yes

Women

Nursing	◯ Yes ◯ No	Pregnant/trying to get pregnant	◯ Yes ◯ No

Are you allergic to any of the following:

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other Allergy ☐ If yes

Comments

Signature of Patient, Parent or Guardian:

X Date:_____

Signature of Doctor:

X Date:_____