Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
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<tbody>
<tr>
<td>Are you under a physician’s care now?</td>
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<tr>
<td>Have you ever been hospitalized or had a major event?</td>
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<td>Has there been a change in your general health since your last visit?</td>
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<tr>
<td>Have you ever been premedicated with antibiotics prior to medical/dental treatment?</td>
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<tr>
<td>Are you on a special diet or nutritional plan? (To lose weight, low salt, diabetic, low cholesterol, ulcer)</td>
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<td>Do you use controlled substances?</td>
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<tr>
<td>Have you taken Phen-Fen or Redux?</td>
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<tr>
<td>Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates</td>
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<tr>
<td>Have you had close contact with or cared for someone with a communicable disease?</td>
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<tr>
<td>Have you traveled outside the state of Illinois in the last 14 days?</td>
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<tr>
<td>Do you have any of the following symptoms or have had any of these symptoms in the last 10 days?</td>
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<td>Fever or chills</td>
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<td>Loss of smell</td>
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<td>Headache</td>
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<td>Nausea</td>
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<td>Sore throat</td>
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<td>Comments:</td>
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Women: Are you...
- Pregnant/Trying to get pregnant?
- Nursing?
- Have you had any complications?

Do you/have you ever used tobacco?
- Yes
- No

Type of tobacco used

How many per day?

How long is/was the habit?

Interested in quitting?

Do you consume alcoholic beverages?
- Yes
- No

What kind?

How many per day?

How long is the habit?
### Allergies

Are you allergic to any of the following?

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<td>Anesthetic</td>
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<td>Environmental (dust, pollen, etc.)</td>
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<td>Iodine</td>
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<td>Other</td>
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<tr>
<td>Aspirin, Ibuprofen, acetaminophen</td>
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<td>Foods, food preservatives/additives, foo</td>
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<td>Penicillin, amoxicillin, etc</td>
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### Do you have, or have you had, any of the following?

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</table>

Have you ever had any serious illness not listed?

- [ ] Yes
- [ ] No

If yes, please specify:

- [ ] Yes

Allergies

Are you allergic to any of the following?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthetic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental (dust, pollen, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iodine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin, Ibuprofen, acetaminophen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foods, food preservatives/additives, foo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penicillin, amoxicillin, etc</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other

- [ ] Yes
- [ ] No

If yes, please specify:

...
### Medications

Are you taking any of the following?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticonvulsants (antiepileptics)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digitalis, heart medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticoagulants (blood thinners)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minerals, vitamins, herb, food supplement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cortisone (steroids), prednisone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin, Diabetes medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressants, antiepileptics, prednisone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antihistamines, decongestants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diuretics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcer medications, acid-reflux medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin, ibuprofen, acetaminophen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nitroglycerine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight control medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchodilators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin, Diabetes medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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<td>Nitroglycerine</td>
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<td></td>
</tr>
</tbody>
</table>

### Vitals and ASA

- BP: [blank]
- Pulse: [blank]
- Respiration: [blank]
- Temperature: [blank]
- ASA: [blank]

### Signatures

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: ____________

Signature of Student Dental Hygienist:

X

Date: ____________