Patient Name:_____

Medical History *Please circle (Y) for "yes" or (N) for "no" for any of the following*

Have you seen a physician or been hospitalized in the last two years (including pregnancy)? Y N

If yes, please explain_____

If yes, Physicians name and phone:_____

Do you take antibiotics before dental treatment and cleanings? Y N
Do you have any of the these conditions: Artificial Heart Valve, Previous Infective Endocarditis, Damaged Heart Valves in Heart Transplant, Unrepaired Cyanotic CHD, Repaired CHD with Residual Defects? Y N

Allergies to anesthetics or drugs such as antibiotics, pain pills, sedatives, aspirin; latex or metals? Y N

If yes, please list_____

Are you currently pregnant? Y N If yes, when are you expecting? _____

Y N High Blood Pressure
Y N Tuberculosis, COPD, or lung problems
Y N Hepatitis A, B, C or D
Y N AIDS or HIV
Y N Excessive Bleeding or Blood Disorder
Y N Diabetes
Y N Dialysis What days? M T W TH F
Y N Asthma
Y N Artificial Joint When?___/___/____

Y N Heart attack or Heart trouble
Y N Chest Pain with exercise (angina)
Y N Stroke
Y N Thyroid Disease
Y N Epilepsy, Seizures, or Fainting
Y N Tumors, Cancer, Radiation Treatment
Y N Psychiatric Disorders
Y N Tobacco How much?_____
Y N Drug/Alcohol Dependency

Other conditions not listed above:_____

_____

What prescriptions or over the counter drugs, medications, vitamins, or herbs are you taking?
Please list: _____

Dental History

On a scale of 0-10, zero being the least and ten being the most, please rate the following:
How healthy your mouth is:____ Dental Anxiety:____ Happy with your Smile:____

Have you ever had any problems associated with previous dental treatment?_____

_____

SLEEP APNEA
Do you feel like you get a good nights sleep? Y N
Do you lack energy or feel tired throughout the day? Y N
Do you have a CPAP machine? Y N
If Yes, do you wear your CPAP? Y N
Are you interested in a sleep evaluation? Y N

I have read the above information and answered accurately. I will not hold Spring Dental responsible for any action taken or not taken because of errors or omissions I may have made on this form.

Patient/Guardian Signature:_____ Date:_____

Dentist/Hygienist Signature: _____Date:_____