*Thank you for allowing Center for Advanced Dentistry to stay informed of your Medical and Personal Information*

**Name:**____________________________________ **DOB:**_______________ **Cell Phone #:**_____________________________

**Address:**___________________________________________________ **Email:** ______________________________________

1. Artificial (prosthetic) heart valve ☐Yes ☐No
2. Damaged valves in transplanted heart ☐Yes ☐No
3. Heart disease/surgery ☐Yes ☐No
4. Heart murmur ☐Yes ☐No
5. Heart Pacemaker ☐Yes ☐No
6. Rheumatic fever/heart disease ☐Yes ☐No
7. High/low blood pressure ☐Yes ☐No
8. Mental health disorder ☐Yes ☐No
9. Bulimia ☐Yes ☐No
10. Tuberculosis ☐Yes ☐No
11. Shortness of breath ☐Yes ☐No
12. Emphysema ☐Yes ☐No
13. Diabetes type I or type II ☐Yes ☐No
14. Persistent swollen glands ☐Yes ☐No
15. Sleep Disorder ☐Yes ☐No
16. HIV Positive/AIDS/ARC ☐Yes ☐No
17. Drug dependency ☐Yes ☐No
18. Blood disorders ☐Yes ☐No
19. Anemia ☐Yes ☐No
20. Prolonged bleeding ☐Yes ☐No
21. Sickle cell disease ☐Yes ☐No
22. Tumors ☐Yes ☐No
23. Radiation therapy ☐Yes ☐No
24. Epilepsy ☐Yes ☐No
25. Arthritis/Rheumatism ☐Yes ☐No
26. Artificial joint/prosthesis ☐Yes ☐No
27. Hepatitis A B C other (circle) ☐Yes ☐No
28. Gastrointestinal disease ☐Yes ☐No
29. Hard of hearing ☐Yes ☐No
30. Cortisone medication ☐Yes ☐No
31. Organ transplant ☐Yes ☐No
32. Osteoporosis ☐Yes ☐No
33. Previous infective endocarditis ☐Yes ☐No
34. Congenital heart disease (CHD)
35. Unrepaired, cyanotic CHD ☐Yes ☐No
    Repaired completely in last 6 months ☐Yes ☐No
    Repaired CHD with residual defects ☐Yes ☐No
36. Mitral valve prolapse ☐Yes ☐No
37. Learning disability ☐Yes ☐No
38. Anorexia ☐Yes ☐No
39. Lung disease / COPD ☐Yes ☐No
40. Asthma ☐Yes ☐No
41. Respiratory ailments ☐Yes ☐No
42. Sinus trouble ☐Yes ☐No
43. Thyroid problems ☐Yes ☐No
44. Kidney problems ☐Yes ☐No
45. Venereal disease ☐Yes ☐No
46. Alcohol addiction ☐Yes ☐No
47. Chemical dependency ☐Yes ☐No
    EX._________________________________
48. Leukemia ☐Yes ☐No
49. Hemophilia ☐Yes ☐No
50. Cancer ☐Yes ☐No
51. Chemotherapy ☐Yes ☐No
52. Neurological disorders ☐Yes ☐No
53. Stroke ☐Yes ☐No
54. Autoimmune Disease ☐Yes ☐No
55. Liver disease ☐Yes ☐No
56. Ulcers ☐Yes ☐No
57. GERD (gastric reflux) ☐Yes ☐No
58. Glaucoma ☐Yes ☐No
59. Fainting spells ☐Yes ☐No
60. Removal of spleen ☐Yes ☐No

**Current Medications:** ________________________________________________________________________________________
__________________________________________________________________________________________________

**Allergic to (circle all that apply): Latex Codeine Antibiotics PNC Sulfa Dental Anesthetics Other:** ____________________

**Any hospitalizations, serious illness or change in health status since your last visit?** ☐Yes ☐No __________________________________

**Do you smoke Cigarettes, Pipe, Cigar, E-Cigarettes or use Smokeless Tobacco?**____________How Often?_________________________

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**BIPHOSPHONATES:** Have you ever or are you currently taking or scheduled to begin taking: alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for osteoporosis or Paget's disease? ☐YES ☐NO

**Do you have ARTIFICIAL JOINTS or HEART PROBLEMS that require you to take a PREMEDICATION prior to dental work?** ☐YES ☐NO

**Do you experience: HEADACHES?** ☐YES ☐NO **JAW PAIN?** ☐YES ☐NO **TMJ ISSUES?** ☐YES ☐NO

**Have you had BOTOX or DERMAL FILLERS before?** ☐YES ☐NO

**Women:** Are you PREGNANT? ☐Yes ☐No Are you NURSING?☐Yes ☐No Are you taking BIRTH CONTROL PILLS? ☐Yes ☐No

Patient /Guardian (if under age 18) Signature: ________________________________ Date: ___________________