**Learman Dental**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last physical exam: \_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your general health? GOOD FAIR POOR

Are you currently under the care of a physician? YES NO

If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL CONDITIONS: Male:**

Y N Significant weight change Y N Prostate disorders

Y N Present/past tobacco use (smoke or chew)

How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Female:**

Y N Present/past alcohol use Y N Pregnant; # months \_\_\_

How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due date \_\_\_\_\_\_\_\_\_\_\_

Y N Present/past recreational drug use Y N Breast-feeding

Y N Birth control pills

**SPECIFIC CONDITIONS:** **Endocrine**

**Skin** Y N Diabetes

Y N Eruptions/rash/hives Y N Thyroid condition

Y N Frequent cold sores/fever blisters Y N Hormone imbalance

**Eyes:** **Nervous system**

Y N Visual changes Y N Stroke

Y N Glaucoma Y N Epilepsy/seizures

Y N Contact lenses Y N Head or neck injuries

Y N Other/surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Numbness/tingling

**Ears:** Y N Dizziness/fainting

Y N Hearing loss **Bones, muscles**

Y N Ringing in ears Y N Arthritis/Rheumatism

Y N Pain/discomfort around ears Y N Artificial joints/limbs

**Respiratory:** Y N Osteoporosis

Y N Tuberculosis Y N Fibromyalgia

Y N Emphysema **Digestive**

Y N Asthma/hay fever Y N Hepatitis (Type \_\_\_\_\_)

Y N Hoarseness/sore throat Y N Ulcers

Y N Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Colitis

Y N Gastric Reflux (GERD)

Y N Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OVER**

**Heart, blood vessels** **OTHER**

Y N Heart problems/trouble Y N Cancer

Y N Chest pain/discomfort Y N Radiation/Chemotherapy

Y N Heart murmur Y N Lumps/growths

Y N Mitral valve prolapse Y N HIV/AIDS

Y N Congenital heart defect Y N Emotional problems

Y N Pacemaker Y N Easily upset or irritated

Y N Artificial heart valve Y N Unhappy/ depressed

Y N High/Low Blood Pressure Y N Psychiatric treatment

Y N Heart surgery Y N Human Papilloma (HPV)

Y N High cholesterol **ALLERGIES, REACTIONS:**

Y N Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Y N Dental anesthesia

**Urinary:** Y N Penicillin/other \_\_\_\_\_\_

Y N Kidney disease Y N Sulfa drugs

Y N Venereal disease Y N Aspirin/Codeine

Y N Increased frequency of urination Y N Barbiturates/sedatives

**Blood:** Y N Latex

Y N Anemia or other blood disorders Y N Metals/jewelry

Y N Bruise easily Y N Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have You Ever Taken Any of These Medications:** **SLEEP MEDICINE:**

Y N Bisphosphonates Y N Snore or Gasp?

Y N Actonel Y N Tired during the day?

Y N Boniva Y N Ever had sleep test?

Y N Fosamax When \_\_\_\_\_ Where\_\_\_\_\_\_\_\_\_

Y N Reclast Y N Diagnosed Sleep Apnea

Y N Zometa Y N Wear CPAP?

Y N Clench or grind teeth?

Y N Headaches or sore jaw?

**MEDICATIONS:**

Please list names of current medication(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any other diseases, conditions or problems not listed that you think we should know about?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is true to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider, who may release such information to you. I will inform you of any changes in my health or medications.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_