PATIENT'S HEALTH INFORMATION
6 month review

Date of Last Dental visit:

Have you had any of the following health problems, conditions or habits since your last visit?

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

Current medications: _____

_____

_____

_____

Allergies to medications: _____

Have you been hospitalized recently? ☐Yes ☐No If yes, please explain: _____

_____

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

Women:

9. Are you pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No
10. Are you taking birth control pills? ☐Yes ☐No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient /Guardian Signature _____ Date _____

Doctor Signature _____ Date _____

NAME: **CHART#:**

Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.