The personal information and medical history requested below is to enable Dr. Summer Kleidosty, DMD to evaluate your dental health thoroughly and completely. It is important for you to give complete answers to that we may give you the personal attention that you deserve. This will become part of your dental record and will be kept in the strictest confidence. Thank you.

Personal Information

Date___________________

Patient Name ____ Date of Birth____________________

Health History

Please circle YES or NO to any of the following:

Abnormal Bleeding	YES	NO
Alcohol Abuse	YES	NO
Allergies	YES	NO
Anemia	YES	NO
Angina Pectoris	YES	NO
Arthritis	YES	NO
Artificial Heart Valve	YES	NO
Asthma	YES	NO
Blood Transfusion	YES	NO
Cancer	YES	NO
Chemotherapy	YES	NO
Colitis	YES	NO
Congenital Heart Defect	YES	NO
Diabetes	YES	NO
Difficulty Breathing	YES	NO
Drug Abuse	YES	NO
Emphysema	YES	NO
Epilepsy	YES	NO
Facial Blister	YES	NO
Glaucoma	YES	NO
HIV	YES	NO
Aids	YES	NO
Heart Attack	YES	NO
Heart Murmurs	YES	NO
Heart Surgery	YES	NO
Hemophilia	YES	NO
Hepatitis A	YES	NO
Hepatitis B	YES	NO
Hepatitis C	YES	NO
High Blood Pressure	YES	NO

Joint Replacement	YES	NO
Joint Replacement date: ___________		
Kidney Problems	YES	NO
Liver Disease	YES	NO
Low Blood Pressure	YES	NO
Mitral Valve Prolapse	YES	NO
Pace Maker	YES	NO
Psychiatric Problems	YES	NO
Radiation Therapy	YES	NO
Seizures	YES	NO
Shingles	YES	NO
Sickle Cell Disease	YES	NO
Sinus problems	YES	NO
Stroke	YES	NO
Thyroid Problems	YES	NO
Tuberculosis	YES	NO
Ulcers	YES	NO

ALLERGIES: Do you have any of the following?

Aspirin	YES	NO
Codeine	YES	NO
Dental Anesthetics	YES	NO
Erythromycin	YES	NO
Latex	YES	NO
Metals	YES	NO
Penicillin	YES	NO
Sulfa	YES	NO
Tetracycline	YES	NO

Other: ____________________________

____

Please circle if you have EVER taken any of the following Bishosphonates:

Actonel	YES	NO
Bonefos	YES	NO
Boniva	YES	NO
Didronel	YES	NO
Skelid	YES	NO
Zometa	YES	NO

Do you Smoke?	YES	NO
Do you take birth control?	YES	NO
Are you pregnant?	YES	NO
Are you nursing?	YES	NO

Please list any other medications you are taking: ____

____

Signature ____ Date _________________________