Chart No.

Purple Vine DENTAL

Please fill in the required information

Patient Information

Name: _____ (Last / First / Middle)

If Child - Parent's Name: _____ (Last / First / Middle)

Birth Date: _____ Soc. Sec.: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's Gender: Male ○ Female ○ Your E-mail Address: _____

Patient Medical History

Physician: _____ Office Phone: _____ Date of Last Exam: _____

YES	NO	
○	○	1. Are you under medical treatment now?
○	○	2. Have you ever been hospitalized for any surgical operation or serious illness?
○	○	3. Are you taking any medications including non-prescription medicine? If yes, what medications are you taking? _____ _____ _____
○	○	4. Do you use tobacco? How many packs per day?_____ For how many years?_____
○	○	5. Do you drink alcohol? If so, how often?_____
		6. Do you use:
○	○	Cocaine
○	○	Methamphetamines
○	○	Other recreational drugs _____
○	○	7. Do you drink coffee, tea or other beverages containing caffeine?
○	○	8. Have you ever taken any bisphosphonate drugs for osteoporosis?
		9. Are you allergic to or have you had any reactions to the following?
○	○	Local anesthetics (e.g., novacaine)
○	○	Penicillin or other antibiotics
○	○	Sulfa Drugs
○	○	Barbiturates
○	○	Sedatives
○	○	Aspirin
○	○	Latex
○	○	Metals of Any Kind
○	○	Other _____

YES	NO	
		10. Do you have or have you had any of the following?
○	○	High Blood Pressure
○	○	Low Blood Pressure
○	○	Heart Disease
○	○	Heart Attack
○	○	Stroke
○	○	Chest Pains
○	○	Heart Murmur
○	○	Rheumatic Fever
○	○	Cardiac Pacemaker
○	○	Artificial Heart Valve
○	○	Artificial Joints or Prostheses
○	○	Swollen Ankles
○	○	Anemia
○	○	Leukemia
○	○	Fainting
○	○	Epilepsy/Seizures/Convulsions
○	○	Diabetes
○	○	Asthma
○	○	Emphysema
○	○	Tuberculosis
○	○	Other Respiratory Problems _____
○	○	Kidney Problems
○	○	Liver Problems
○	○	Thyroid Problem
○	○	Stomach Problems/Ulcers
○	○	Cancer
○	○	Radiation Therapy
○	○	Arthritis
○	○	Glaucoma
○	○	AIDS or HIV Infection
○	○	Hepatitis - if yes, what type _____
○	○	Hay Fever/Allergies
○	○	Sexually Transmitted Diseases - if yes, what type _____
○	○	Other _____
		11. Women Only:
○	○	a) Are you pregnant or think you may be pregnant?
○	○	b) Are you nursing?
○	○	c) Are you taking birth control pills?

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