DENTAL WALK IN CLINIC OF TAMPA BAY
4240 W KENNEDY BLVD
TAMPA, FLORIDA 33609
813.636.9400

Patient Name _____ Date of Birth _____

I. Circle Appropriate Answer (Leave blank if you do not understand)

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized, had surgery, or had a serious illness in the past?
   If yes, why?_____
4. Yes No Are you being treated by a physician now? For What? _____
   Date of last medical exam?_____ Date of last dental exam? _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. Have You Experienced:

7. Yes No Chest pain? (Angina)
8. Yes No Swollen Ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred Vision?
23. Yes No Seizures?
24. Yes No Excessive Thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. Do You Have Or Have You Had:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic Fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma, Tuberculosis, emphysema
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: Drugs, foods, medications, latex?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (Syphilis or gonorrhea?)
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?
51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joints?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

IV. Are You Taking:

61. Yes No Recreational drugs?
62. Yes No Drugs, medications, over the counter medicines (including Aspirin) or natural remedies?
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

Please list: _____

V. Women Only:

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?

VI. All Patients:

67. Yes No Do you have or have you had any other disease or medical problems NOT listed on this form?

If so, please explain: _____

PATIENT'S SIGNATURE: _____ **DATE:** _____

I understand that it is my responsibility to disclose and update the Dental Walk-In Clinic of any changes in my medical history or medications taken prior to each appointment. I understand that the Dental Walk-In Clinic may not be able to treat my chief complaint due to my medical history. I understand that the Dental Walk-In Clinic will not be held liable for my failure to do the above. I confirm that the below medications and information regarding how the medications are being taken is correct and will inform the Dental Walk-In Clinic of any changes in my medical history and medications. **Patient or Legal Guardian's Initials _____**

If you are taking medications, please list:

Name of Medication	Dose	Directions	How long on Medication

********** HISTORY OF ALLERGY **********

Local Anesthetic	YES OR NO	Aspirin OR Ibuprofen	YES OR NO
Penicillin	YES OR NO	Iodine	YES OR NO
Other Antibiotic	YES OR NO	Latex	YES OR NO
Sedatives	YES OR NO	Codeine/Other narcotics	YES OR NO

Please describe your reaction to the allergen: _____

Have you ever had an emergency in the Dental Office requiring medical attention? **Yes or No**

Have you ever, or are currently taking **blood thinners**? (Coumadin/Warfarin, Heparin/Lovenox, Plavix, Aspirin, OTHER) **Yes or No**
**If YES, How long on medication _____, why on medication _____, last time seen prescribing Doctor _____?

If you answered **YES to high blood pressure, when were you diagnosed _____, What is your usual pressure reading _____, How often do you see your doctor for a checkup _____?

If you answered **YES to history of heart attack/stroke, when _____?

Have you ever been given antibiotics an hour before a dental procedure? **Yes or No If YES, Why?
_____

If you answered **YES to heart murmur, history of rheumatic fever, mitral valve prolapsed, or damaged/artificial heart valves, when were you diagnosed? _____ Instructions regarding premedication? _____?

If you answered **YES to artificial joint(s), what joint(s) _____, when _____, were you instructed to take premedication? _____

If you answered **YES to diabetes, what type _____, are you controlled _____, sugar level when tested _____, how often do you check it? _____

If you answered **YES to history of cancer, what type _____, when _____, name of Doctor/hospital treated _____, are you currently undergoing chemotherapy _____, when was last chemotherapy taken if not currently taking _____, Did you have radiation in the area of the head/neck _____?

Are you currently, or have you ever taken Bisphosphonate drugs for the prevention of osteoporosis, treatment of Paget's disease, or certain cancers? (Ex Fosamax, Zometa, Aredia, Actonel, Reclast, Didronel etc) **YES OR NO

_____ DO NOT FILL OUT BELOW _____

Patient's initial Blood Pressure/Pulse: _____ Date: _____
It is safe to perform routine dentistry including surgical extractions on the above patient: **YES or NO**
Doctor: _____ Date: _____
A medical clearance letter has been requested from Doctor: _____ at _____, Date _____
Doctor's notes: _____