Dr. Julie A. F. Herndon 14375 Saratoga Ave #100, Saratoga CA 95070

Patient's Name: _____ Date of Birth: _____

Physician (M. D.): _____ M.D. Phone: _____

Last physical exam?: _____ Date of last dental exam?: _____ Gender: ☐ Male ☐ Female

Circle Appropriate Answer (*leave blank if you do not understand question*):

☐ Yes ☐ No Are you currently under the care of a physician? If yes, for what? _____

☐ Yes ☐ No Are you taking any medications or drugs at this time? If yes, list? _____

☐ Yes ☐ No Have you had an major medical surgeries? If yes, please explain: _____

☐ Yes ☐ No Any allergies to latex or problems with any medications you have taken? If yes, list: _____

☐ Yes ☐ No Has a physician ever prescribed an medications before dental treatments?

Do you have or have you had?

☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No	Anemia
☐ Yes	☐ No	Asthma/Hayfever	☐ Yes	☐ No	Fainting o Dizzy spells
☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Epilepsy or Seizures
☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Emphysema/Chronic Lung Problems	☐ Yes	☐ No	Arthritis / Rheumatisms
☐ Yes	☐ No	Prosthesis (artificial joint)	☐ Yes	☐ No	Ulcers, Stomach Problems
☐ Yes	☐ No	Prosthetic Heart Valve	☐ Yes	☐ No	Glaucoma, Eye Disease
☐ Yes	☐ No	Pace Maker	☐ Yes	☐ No	Thyroid, Adrenal Disease
☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Cancer / Tumors
☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Radiation / Chemotherapy
☐ Yes	☐ No	Heart Murmur / Heart Defects	☐ Yes	☐ No	Kidney or Bladder Disease
☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Hepatitis / Liver Disease
☐ Yes	☐ No	Chest Pain (Angina)	☐ Yes	☐ No	AIDS or HIV test positive
☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No	Blood Transfusion
☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Herpes (cold sores)
☐ Yes	☐ No	Clotting (bleeding) Problems	☐ Yes	☐ No	Venereal Disease
☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Alcohol / Chemical Dependency
☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Psychiatric Care
☐ Yes	☐ No	Medication for Osteoporosis	☐ Yes	☐ No	Used Bisphosphonates

Women Only:

☐ Yes ☐ No Are / could you be pregnant? ☐ Yes ☐ No Taking birth control pills?

All Patients:

☐ Yes ☐ No Have you ever had an unfavorable reaction to dental treatment?

☐ Yes ☐ No Have you had any Periodontal treatment (gum disease)?

☐ Yes ☐ No Have you ever had a tooth or gum abscess?

☐ Yes ☐ No May we have permission to contact your Physician?

How uncomfortable are you in a dental office? ☐ Extremely ☐ Mildly ☐ Not at All

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's Signature: _____ Date: _____