

**ADULT & IMPLANT
DENTISTRY**
Of Ventura County
Dental Practice of Richard Gagne, D.D.S., Inc.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you been under the care of a physician during the past two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain _____ | | |
| 2. Have you ever had cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how was it treated? Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Other <input type="checkbox"/> | | |
| 3. Have you had a heart attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| Year _____ | | |
| 4. Have you ever been told that you need antibiotics prior to dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| Packs Per Day _____ | | |
| 6. Do you have pain in your chest, shortness of breath, or tiredness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do your ankles swell during the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you ever wake up from sleep short of breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you snore at night? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you taken any illegal drugs in the past? (Failure to disclose could cause serious harm to you) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. WOMEN: Is there a possibility that you might be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had the inability to get "numb" from local anesthetics? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you had a bad dental experience in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Please list any medications that you are presently taking on the line below: | | |

15. Please check YES or NO to the following health conditions

	Yes	No		Yes	No		Yes	No
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorders	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone medications	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Chronic coughs	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Fen-phen or Redux Usage	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>			

16. Are you allergic to any of the following:

- | | Yes | No | | Yes | No |
|--------------------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|
| Latex products or latex gloves | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> |
| Non-Gold jewelry | <input type="checkbox"/> | <input type="checkbox"/> | Codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other (please list) | <input type="checkbox"/> | <input type="checkbox"/> |

Your Signature _____

Date _____

FOR OFFICE USE ONLY					
Date	Doctor	ASA	Date	Doctor	ASA
_____	_____	_____	_____	_____	_____