

DO YOU HAVE OR HAVE YOU EVER HAD:

| <i>(Check each item)</i> | YES | NO | DON'T KNOW | <i>(Check each item)</i> | YES | NO | DON'T KNOW | <i>(Check each item)</i> | YES | NO | DON'T KNOW |
|--|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| Epilepsy or Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart problems or Angina | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers (mouth or stomach) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression, Anxiety, or Nervousness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hypertension (high blood pressure) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastroesophageal reflux (GERD) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental health conditions (including PTSD) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eating disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurologic disorders (including TBI) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur or Heart defect | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma (narrow or wide angle) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraine or Chronic headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting or Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Infective endocarditis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Steroid medication(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic (artificial) heart valve(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hives | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (rheumatoid or osteoarthritis) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema, Bronchitis, or Lung disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful joints (including jaw) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prosthetic (artificial) joint(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis / PPD positive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism or Alcohol abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic sinusitis/Recurring sinus infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis - Type: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drug dependency or Drug abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold sores (herpes) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Unexplained weight change | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sickle cell disease / trait | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy or Radiation treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G-6PD deficiency | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIV+ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding problems or Bruise easily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of bisphosphonate use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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|---|--|--------------------------|--------------------------|--------------------------------------|--|
| Check each item below and describe any "Yes" answers to the right: | | YES | NO | Describe "Yes" answers below: | |
| 1. Do you have any <u>allergies</u> (medications, latex, metals, food, etc.)? | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 2. Are you currently taking any <u>medications</u> (over-the-counter, prescription, etc.)? | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 3. Are you presently using any herbals, energy drinks, or supplements (such as ginseng, ginkgo biloba, willow bark, guarana extract, etc.)? | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 4. Have you ever been hospitalized (including cancer treatment)? | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 5. Are you currently under the care of a physician? | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 6. Do you have any disease or condition not listed above? | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 7. Are you currently experiencing abuse, neglect, or depression? | | <input type="checkbox"/> | <input type="checkbox"/> | | |

| | | | | | | | | | | | |
|---|--|--------------------------|--------------------------|------------------------------------|--|--------------------------|--------------------------|--------------------------------------|--|--------------------------|--------------------------|
| 8. HAVE YOU EVER: | | YES | NO | 9. ARE YOU IN: | | YES | NO | 10. FEMALES, ARE YOU: | | YES | NO |
| 8a. Been told not to donate blood? | | <input type="checkbox"/> | <input type="checkbox"/> | 9a. Flight status? | | <input type="checkbox"/> | <input type="checkbox"/> | 10a. On birth control? | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8b. Used antibiotics before dental treatment? | | <input type="checkbox"/> | <input type="checkbox"/> | 9b. Personnel Reliability Program? | | <input type="checkbox"/> | <input type="checkbox"/> | 10b. Pregnant? (Est. delivery date?) | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8c. Used antibiotics for a prolonged period? | | <input type="checkbox"/> | <input type="checkbox"/> | | | | | 10c. Breast feeding? | | <input type="checkbox"/> | <input type="checkbox"/> |

10. Any family history of:
 Cancer Heart disease
 Diabetes High blood pressure

11. Any social history of (if no, write "none"):
 Tobacco use (including E-cigarettes/vapor products) *Type and Frequency:* _____ *Years used:* _____
 Alcohol consumption *Type and Frequency:* _____

| | | | | | | |
|----------------------------|------|---------------------|--------------------------|------|--------------------------|------------------------------|
| 1. | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Patient/Guardian Signature | Date | Dental Officer Name | Dental Officer Signature | Date | Learning Needs Assessed | Patient Identifiers Verified |
| 2. | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Patient/Guardian Signature | Date | Dental Officer Name | Dental Officer Signature | Date | Learning Needs Assessed | Patient Identifiers Verified |
| 3. | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Patient/Guardian Signature | Date | Dental Officer Name | Dental Officer Signature | Date | Learning Needs Assessed | Patient Identifiers Verified |

SUMMARY OF PERTINENT FINDINGS/RECOMMENDED TREATMENT MODIFICATIONS (*Office use only*):

| | | | |
|--|-------------------|-----------------------------|---------------------------------------|
| Patient Name (Last, First, Middle Initial) | Sex | Date of Birth (DD/MMM/YYYY) | Grade/Rate or Relationship to Sponsor |
| Sponsor's Name (if different from above) | Branch of Service | Active/Reserve | DOD Identification Number |