STUART E. ALEXANDER, D.M.D.

19 North Main St
Cranbury, NJ 08512
Telephone: (609) 395-8383

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you have fever or have you felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you in contact with any confirmed COVID-19 positive patients?	☐ Yes ☐ No	☐ Yes ☐ No
Is your age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Please sign and date.

X_____ Date _____

DENTAL HEALTH HISTORY UPDATE

(Confidential)

Chart Color
☐ RED ☐ GREY
(For office use only)

Patient: _____ **Birthdate:** ____/____/_____

Reason For Today's Visit (Chief Complaint): _____

MEDICAL HISTORY

Primary Physician's name: _____ **Date of Last Visit:** ____/____/_____

Have you ever been hospitalized? ☐YES ☐NO **If yes, most recent date:** ____/____/_____

Have you ever had a blood transfusion? ☐YES ☐NO **If yes, give date(s):** ____/____/_____

WOMEN ONLY: **Are you pregnant?** ☐YES ☐NO **Nursing?** ☐YES ☐NO **Taking birth control pills?** ☐YES ☐NO

CHECK (✓) IF YOU HAVE HAD ANY OF THE FOLLOWING:

- ☐ AIDS
- ☐ ANEMIA
- ☐ ATHRITIS/RHEUMATISM
- ☐ ARTIFICIAL HEART VALVES
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BLOOD DISEASE
- ☐ CANCER
- ☐ CHEMICAL DEPENDENCY
- ☐ CHEMOTHERAPY
- ☐ CIRCULATORY PROBLEMS
- ☐ COLD SORES
- ☐ CORTISONE TREATMENTS
- ☐ CHRONIC COUGHING
- ☐ COUGHING UP BLOOD
- ☐ DIABETES
- ☐ DEMENTIA
- ☐ EATING DISORDER
- ☐ EPILEPSY/SEIZURES
- ☐ FAINTING SPELLS/DIZZINESS
- ☐ GLAUCOMA
- ☐ CHRONIC HEADACHES
- ☐ HEART MURMUR
- ☐ HEART ATTACK/FAILURE
- ☐ HEART PROBLEM/DISEASE
- ☐ HERPES
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV POSITIVE
- ☐ JAW PAIN
- ☐ KIDNEY PROBLEMS/DISEASE
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ LUNG DISEASE
- ☐ MITRAL VALVE PROLAPSE
- ☐ NERVOUS/ANXIETY PROBLEMS
- ☐ ORGAN TRANSPLANT
- ☐ PACEMAKER
- ☐ PARATHYROID PROBLEM/DISEASE
- ☐ PYSCHIATRIC CARE/MENTAL DISORDER
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SHORTNESS OF BREATH
- ☐ STROKE
- ☐ STOMACH/INTESTINAL PROBLEMS
- ☐ SWELLING OF FEET OR ANKLES
- ☐ THYROID PROBLEMS
- ☐ TOBACCO HABIT
- ☐ TONSILITIS
- ☐ TUBERCULOSIS
- ☐ TUMORS/GROWTHS
- ☐ ULCER
- ☐ OTHER _____

Have you ever been pre-medicated for a previous dental treatment? ☐YES ☐NO

MEDICATIONS

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

Pharmacy Name: _____

Address: _____

Phone Number: _____

ALLERGIES

- ☐ **Aspirin**
- ☐ **Antibiotics**
- ☐ **Codeine**
- ☐ **Sulfa**
- ☐ **Penicillin**
- ☐ **Latex**
- ☐ **Local Anesthetic**
- ☐ **Other:** _____

☐ **NONE**

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ **Date:** ____/____/_____

Stuart E. Alexander, DMD 19 North Main Street · Cranbury, NJ 08512 609-395-8383 alexanderdental@aol.com