Robert A Saunders DDS
2834 S University Drive
Fargo, ND 58103-6030
(701)293-9886

Are you now under the care of a physician?

◯ Yes ◯ No

Physician Name Phone Number

Address/City/State/Zip:

Are you in good health?

◯ Yes ◯ No

Has there been any changes in your general health within the past year?

◯ Yes ◯ No

If yes what condition is being treated?

Date of last physical exam:

Have you had a serious illness,operation or been hospitalized in the past 5 years?

◯ Yes ◯ No

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine?

◯ Yes ◯ No

If so, please list all including vitamins, natural or herbal preparations and/or dietary supplements?

JOINT REPLACEMENT. Have you had any type of joint replacement: hip, knee, elbow, etc? Date: If yes, have you had any complications?

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Are you taking or have been scheduled to begin taking any bone replacement agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia)? If so, Date of Treatment:

Please mark (X) your response to indicate if you have or have had any of the following diseases or problems.

- [ ] Artificial (prosthetic) heart valve, Previous infective endocarditis, Damaged valves in transplanted heart, Congenital heart disease (chronic heart disease), Unrepaired cyanotic CHD repaired (completely) in last 6 months, or Repaired CHD with residual defects

Do you have or had any of the following:

- [ ] Cardiovascular Disease
- [ ] Arteriosclerosis
- [ ] Congestive Heart Failure
- [ ] Other Congenital Heart Defects
- [ ] Rheumatic Heart Disease
- [ ] Blood Transfusion
- [ ] Arthritis

- [ ] *PreMed
- [ ] Abnormal Bleeding
- [ ] Allergy Codeine
- [ ] Allergy Erythromycin
- [ ] Allergy Latex
- [ ] Allergy Penicillin
- [ ] Allergy Sulfa
- [ ] Allergy-Asprin
- [ ] Allergy-Clindamycin
- [ ] Anemia
- [ ] Angina
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Thinners
- [ ] Cancer
- [ ] Damaged Heart Valves
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Headaches-Migraines
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Kidney Disease
- [ ] Leaky Heart Valve
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] MitralValve Prolapse
- [ ] Pacemaker
- [ ] Radiation Tx
- [ ] Reflux-Heartburn
- [ ] Rheumatic Fever
- [ ] Rheumatoid Arthritis
- [ ] Sleep Disorder
- [ ] Stroke
- [ ] Tuberculosis

Any additional medical concerns:

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Do you use controlled substances (drugs)?

◯ Yes ◯ No

Do you use tobacco as in smoking, snuff, chew, or bidis?

◯ Yes ◯ No

If so, how interested are you in stopping?

Do you drink alcoholic beverages?

◯ Yes ◯ No

If yes, how much alcohol did you drink in the last 24 hours? How much do you typically drink in a week?

Women only:
Are you Pregnant?
Number of weeks?
Nursing?
Taking birth control pills or hormonal replacement?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Name of physician or dentist making recommendation? Do you have any disease, condition, or problem not listed above that you think I should know about?

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Response Date: