

Linda J. Ruppel, D.D.S.

Prosthodontist and Certificate in Geriatrics

7669 Emerald Street • Boise, ID 83704

(208) 377-5523

Name _____ Date of Birth _____

Circle One:

Status: Minor Single Married Divorced Widowed

Person Accompanying: Spouse Caregiver Friend Family Member Driver/Name _____

Living Environment: Home Assisted Living Nursing Care Facility w/Family or Friend _____

Physician _____ City _____ State _____

Approximate date of last physical exam _____

- Circle one**
- Y N 1. Are you under any medical treatment now?
- Y N 2. Have you ever had a serious accident involving head injuries?
- Y N 3. Have you ever had radiation treatments or chemotherapy?
- Y N 4. Do you have pain in or near your ears?
- Y N 5. Do you have any unhealed injuries or inflamed areas in or around your mouth?
- Y N 6. Have you experienced any growth or sore spots in your mouth?
- Y N 7. Does any part of your mouth hurt when clenched? Y N Do your gums bleed easily?
- Y N 8. Do you habitually clench your teeth during the night or day?
- Y N 9. Have you ever had teeth removed? Dates _____
- Y N 10. Do you at the present time have any dental complaints? _____
If yes, what _____

When was the last time you saw a dentist? _____

When was your last full mouth X-RAY taken? _____ Where? _____

Circle any of the following which you have or had:

- | | | | |
|------------------------|--------------------------|-------------------------|--------------------------------|
| Alzheimer's, Dementia | COPD or Emphysema | Heart Murmur | Parkinson's |
| Anorexia, Bulimia | Diabetes, Kidney Disease | Hepatitis | Pregnant # _____ C-Sect. _____ |
| Artificial Joints | Drug, Alcohol Problem | High Blood Pressure | Prolonged Bleeding |
| Arthritis (Rheumatoid) | Epilepsy or Seizures | High or Low Cholesterol | Recent Weight Loss |
| Asthma | Fainting | HIV Virus | Rheumatic Fever |
| Cancer | Gerd (Reflux Disorder) | Latex Allergy | Stroke, TIAS |
| Chemo or Radiation | Glaucoma | Macular Degeneration | TB - Tuberculosis |
| Cold Sores, Ulcers | Heart Condition, Surgery | Osteoporosis | Thyroid Problems |
| | | Pacemaker | Venereal Disease |

List drugs or medications currently taking _____
or give to Dental Assistant to be copied _____

SBE: Antibiotic taken prior to dental appt: _____

List drugs or materials causing an allergic reaction _____

List major surgeries and dates _____

List other disease _____
blood, liver, kidney, stomach, intestine

Do you use - glasses contacts hearing aids cane walker wheelchair

I understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

Person Responsible