

PATIENT NAME _____ DATE OF BIRTH _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medication, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biophosphonates? Yes No If yes, please explain: _____

Are you on a special diet? Yes No If yes, please explain: _____

Do you use tobacco? Yes No If yes, please explain: _____

Do you use controlled substances? Yes No If yes, please explain: _____

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal

Latex Sulfa Drugs Other: _____

If yes, please explain: _____

Women - Are you:

...pregnant/trying to get pregnant? _____ ...nursing? _____ ...taking oral contraceptives? _____

Do you have, or have you had, any of the following?

AIDS/HIV+	Y N	Epilepsy or Seizures	Y N	Lung Disease	Y N
Alzheimer's	Y N	Excessive Bleeding	Y N	Mitral Valve Prolapse	Y N
Anaphylaxis	Y N	Excessive Thirst	Y N	Osteoporosis	Y N
Anemia	Y N	Fainting Spells/Dizziness	Y N	Pain in Jaw Joints	Y N
Angina	Y N	Frequent Cough	Y N	Parathyroid Disease	Y N
Arthritis/Gout	Y N	Frequent Diarrhea	Y N	Psychiatric Care	Y N
Artificial Heart Valve	Y N	Frequent Headaches	Y N	Radiation Treatments	Y N
Artificial Joint	Y N	Genital Herpes	Y N	Recent Weight Loss	Y N
Asthma	Y N	Glaucoma	Y N	Renal Dialysis	Y N
Blood Disease	Y N	Hay Fever	Y N	Rheumatic Fever	Y N
Blood Transfusion	Y N	Heart Attack/Failure	Y N	Rheumatism	Y N
Breathing Problem	Y N	Heart Murmur	Y N	Scarlet Fever	Y N
Bruise Easily	Y N	Heart Pacemaker	Y N	Shingles	Y N
Cancer	Y N	Heart Trouble/Disease	Y N	Sickle Cell Disease	Y N
Chemotherapy	Y N	Hemophilia	Y N	Sinus Trouble	Y N
Chest Pains	Y N	Hepatitis A	Y N	Spina Bifida	Y N
Cold Sores/Fever Blisters	Y N	Hepatitis B or C	Y N	Stomach/Intestine Disease	Y N
Congenital Heart Disorder	Y N	Herpes	Y N	Stroke	Y N
Convulsions	Y N	High Blood Pressure	Y N	Swelling of Limbs	Y N
Cortisone Medicine	Y N	High Cholesterol	Y N	Thyroid Disease	Y N
Diabetes	Y N	Hives or Rash	Y N	Tonsillitis	Y N
Drug Addiction	Y N	Hypoglycemia	Y N	Tuberculosis	Y N
Easily Winded	Y N	Irregular Heartbeat	Y N	Tumors or Growths	Y N
Emphysema	Y N	Kidney Problems	Y N	Ulcers	Y N
		Leukemia	Y N	Venereal Disease	Y N
		Liver Disease	Y N	Yellow Jaundice	Y N
		Low Blood Pressure	Y N	Other: _____	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the office of any changes in medical status.

Signature: _____ Date: _____