

Time :

Date :

Patient Name:

Beth Date:

Date Created:

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 _____

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

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

Are you taking any medications, pills, or drugs? Yes No If yes _____

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

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Sulfu Drugs

Local Anesthetics

Other?

If yes _____

Do you use controlled substances? Yes No

If yes _____

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

AIDS/HIV Positive Yes No

Corticone Medicine Yes No

Hemophilia Yes No

Radiation Treatments Yes No

Alzheimer's Disease Yes No

Diabetes Yes No

Hepatitis A Yes No

Recent Weight Loss Yes No

Anaphylaxis Yes No

Drug Addiction Yes No

Hepatitis B or C Yes No

Renal Dialysis Yes No

Anemia Yes No

Easily Winded Yes No

Herpes Yes No

Rheumatic Fever Yes No

Angina Yes No

Emphysema Yes No

High Blood Pressure Yes No

Rheumatism Yes No

Arthritis/Gout Yes No

Epilepsy or Seizures Yes No

High Cholesterol Yes No

Scarlet Fever Yes No

Artificial Heart Valve Yes No

Excessive Bleeding Yes No

Hives or Rash Yes No

Shingles Yes No

Artificial Joint Yes No

Excessive Thirst Yes No

Hypoglycemia Yes No

Sickle Cell Disease Yes No

Asthma Yes No

Fainting Spells/Dizziness Yes No

Irregular Heartbeat Yes No

Sinus Trouble Yes No

Blood Disease Yes No

Frequent Cough Yes No

Kidney Problems Yes No

Spina Bifida Yes No

Blood Transfusion Yes No

Frequent Diarrhea Yes No

Leukemia Yes No

Stomach/Intestinal Disorder Yes No

Breathing Problems Yes No

Frequent Headaches Yes No

Liver Disease Yes No

Stroke Yes No

Bruise Easily Yes No

Genital Herpes Yes No

Low Blood Pressure Yes No

Swelling of Limbs Yes No

Cancer Yes No

Glaucoma Yes No

Lung Disease Yes No

Thyroid Disease Yes No

Chemotherapy Yes No

Hay Fever Yes No

Mitral Valve Prolapse Yes No

Tonsillitis Yes No

Chest Pains Yes No

Heart Attack/Failure Yes No

Osteoporosis Yes No

Tuberculosis Yes No

Cold Sores/Fever Blisters Yes No

Heart Murmur Yes No

Pain in Jaw Joints Yes No

Tumors or Growths Yes No

Congenital Heart Disorder Yes No

Heart Pacemaker Yes No

Parathyroid Disease Yes No

Ulcers Yes No

Convulsions Yes No

Heart Trouble/Disease Yes No

Psychiatric Care Yes No

Veneral Disease Yes No

Yellow Jaundice Yes No

Have you ever had any serious illness not listed Yes No If yes _____

Comments:

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 dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

X

Date: _____