

PATIENT NAME _____ Birth Date _____

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 medications, pills, or drugs? Yes No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain: _____

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

- | | | | |
|--|--|--|--|
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| AIDS/HIV Positive | Cortisone Medicine | Hemophilia | Radiation Treatments |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | Diabetes | Hepatitis A | Recent Weight Loss |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | Drug Addiction | Hepatitis B or C | Renal Dialysis |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | Easily Winded | Herpes | Rheumatic Fever |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | Emphysema | High Blood Pressure | Rheumatism |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | Epilepsy or Seizures | Hives or Rash | Scarlet Fever |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | Excessive Bleeding | Hypoglycemia | Shingles |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | Fainting Spells/Dizziness | Irregular Heartbeat | Sickle Cell Disease |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | Frequent Cough | Kidney Problems | Sinus Trouble |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | Frequent Diarrhea | Leukemia | Spina Bifida |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | Frequent Headaches | Liver Disease | Stomach/Intestinal Disease |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | Genital Herpes | Low Blood Pressure | Stroke |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Bruse Easily | Glaucoma | Lung Disease | Swelling of Limbs |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | Hay Fever | Mitral Valve Prolapse | Thyroid Disease |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | Heart Attack/Failure | Osteoporosis | Tonsillitis |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | Heart Murmur | Pain in Jaw Joints | Tuberculosis |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | Heart Pacemaker | Parathyroid Disease | Tumors or Growths |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | Heart Trouble/Disease | Psychiatric Care | Ulcers |
| <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | | | Veneral Disease |
| <input type="radio"/> Yes <input type="radio"/> No | | | <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice |
| | | | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No

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 _____ DATE _____