

Patient Name:

Birth 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

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 ☐ NoDo 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☐ Sulfa Drugs☐ Local AnestheticsOther? ☐

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 ☐ NoCortisone Medicine ☐ Yes ☐ NoHemophilia ☐ Yes ☐ NoRadiation Treatments ☐ Yes ☐ NoAlzheimer's Disease ☐ Yes ☐ NoDiabetes ☐ Yes ☐ NoHepatitis A ☐ Yes ☐ NoRecent Weight Loss ☐ Yes ☐ NoAnaphylaxis ☐ Yes ☐ NoDrug Addiction ☐ Yes ☐ NoHepatitis B or C ☐ Yes ☐ NoRenal Dialysis ☐ Yes ☐ NoAnemia ☐ Yes ☐ NoEasily Winded ☐ Yes ☐ NoHerpes ☐ Yes ☐ NoRheumatic Fever ☐ Yes ☐ NoAngina ☐ Yes ☐ NoEmphysema ☐ Yes ☐ NoHigh Blood Pressure ☐ Yes ☐ NoRheumatism ☐ Yes ☐ NoArthritis/Gout ☐ Yes ☐ NoEpilepsy or Seizures ☐ Yes ☐ NoHigh Cholesterol ☐ Yes ☐ NoScarlet Fever ☐ Yes ☐ NoArtificial Heart Valve ☐ Yes ☐ NoExcessive Bleeding ☐ Yes ☐ NoHives or Rash ☐ Yes ☐ NoShingles ☐ Yes ☐ NoArtificial Joint ☐ Yes ☐ NoExcessive Thirst ☐ Yes ☐ NoHypoglycemia ☐ Yes ☐ NoSickle Cell Disease ☐ Yes ☐ NoAsthma ☐ Yes ☐ NoFainting Spells/Dizziness ☐ Yes ☐ NoIrregular Heartbeat ☐ Yes ☐ NoSinus Trouble ☐ Yes ☐ NoBlood Disease ☐ Yes ☐ NoFrequent Cough ☐ Yes ☐ NoKidney Problems ☐ Yes ☐ NoSpina Bifida ☐ Yes ☐ NoBlood Transfusion ☐ Yes ☐ NoFrequent Diarrhea ☐ Yes ☐ NoLeukemia ☐ Yes ☐ NoStomach/Intestinal Disease ☐ Yes ☐ NoBreathing Problems ☐ Yes ☐ NoFrequent Headaches ☐ Yes ☐ NoLiver Disease ☐ Yes ☐ NoStroke ☐ Yes ☐ NoBruise Easily ☐ Yes ☐ NoGenital Herpes ☐ Yes ☐ NoLow Blood Pressure ☐ Yes ☐ NoSwelling of Limbs ☐ Yes ☐ NoCancer ☐ Yes ☐ NoGlaucoma ☐ Yes ☐ NoLung Disease ☐ Yes ☐ NoThyroid Disease ☐ Yes ☐ NoChemotherapy ☐ Yes ☐ NoHay Fever ☐ Yes ☐ NoMitral Valve Prolapse ☐ Yes ☐ NoTonsillitis ☐ Yes ☐ NoChest Pains ☐ Yes ☐ NoHeart Attack/Failure ☐ Yes ☐ NoOsteoporosis ☐ Yes ☐ NoTuberculosis ☐ Yes ☐ NoCold Sores/Fever Blisters ☐ Yes ☐ NoHeart Murmur ☐ Yes ☐ NoPain in Jaw Joints ☐ Yes ☐ NoTumors or Growths ☐ Yes ☐ NoCongenital Heart Disorder ☐ Yes ☐ NoHeart Pacemaker ☐ Yes ☐ NoParathyroid Disease ☐ Yes ☐ NoUlcers ☐ Yes ☐ NoConvulsions ☐ Yes ☐ NoHeart Trouble/Disease ☐ Yes ☐ NoPsychiatric Care ☐ Yes ☐ NoVenereal Disease ☐ Yes ☐ NoYellow Jaundice ☐ Yes ☐ NoHave 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: _____