

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 If Yes: _____

Do you use tobacco? Yes No If Yes: _____

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Asprin

Penicillin

Codeine

Acrylic

Metal

Latex

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

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

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: _____