Patient Name: **Birth Date:** **Date Created:**

Although dental personnel primarily treat the area in and around the mouth, you mouth is part of your entire body. Health problems that you may not 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 physicians care now? Yes No If yes:_____
Have you 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 medication? Yes No If yes:_____
Have you ever 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:_____
Are you under a physicians care now? Yes No If yes:_____
Do you use tobacco? Yes No If yes:_____
Date of your last dental visit_____

Women are you:
Pregnant/trying to get pregnant Nursing Taking contraceptives

Do you use controlled substances? Yes No If yes, type: _____
Are you allergic to any of the following:

Aspirin Codeine Other? If yes_____
Metal Sulfa Drugs
Penicillin Acrylic
Latex Local Anesthetics

Do you have or have you had any of the following, **check all that apply**:

AIDS/HIV positive	Cortisone Medicine	Hemophilia	Radiation Treatment
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Epilepsy/Seizures	High Blood Pressure	Rheumatism
Arthritis/Gout	Excessive Bleeding	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Thirst	Hives or Rash	Shingles
Artificial Joint	Fainting/Dizziness	Hypoglycemia	Sickle Cell Disease
Asthma	Frequent Cough	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Diarrhea	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Headache	Leukemia	Stomach/Intestinal
Breathing Problems	Genital Herpes	Liver Disease	Stroke
Bruise Easily	Glaucoma	Low Blood Pressure	Swelling of Limbs
Cancer	Hay Fever	Lung Disease	Thyroid Disease
Chemotherapy	Heart Attack/Failure	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Murmur	Osteoporosis	Tuberculosis
Cold Sores/Blisters	Pacemaker	Pain in Jaw Joints	Tumors or Growths
Convulsions	Heart Trouble/Disease	Parathyroid Disease	Ulcers
		Psychiatric Care	Venereal Disease
Have ever had any illness not listed above _____			Yellow Jaundice

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date_____