

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Created:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 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 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 other medications containing bisphosphonates? | **Yes/No If yes:** |
| Are on a special diet? | **Yes/No If yes:** |
| Do you use tobacco? | **Yes/No If yes:** |
| Are you pregnant/trying to get pregnant? | **Yes/No If yes:** |
| Are you nursing? | **Yes/No If yes:** |
| Are you taking oral contraceptives? | **Yes/No If yes:** |

**Are you allergic to any of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
| € Aspirin | € Penicillin | € Codeine | € Acrylic |
| € Metal  | **€ Local Anesthetics** | **€ Sulfa Drugs** | **€ Latex** |
| € Other: |

**Do you use controlled substances? € Yes/ € No If yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **AIDS/HIV Positive** | Y | N | **Excessive Bleeding** | Y | N | **Low Blood Pressure** | Y | N |
| **Alzheimer's Disease** | Y | N | **Excessive Thirst** | Y | N | **Lung Disease** | Y | N |
| **Anaphylaxis** | Y | N | **Fainting/Dizziness** | Y | N | **Mitral Valve Prolapse** | Y | N |
| **Anemia** | Y | N | **Frequent Cough** | Y | N | **Osteoporosis** | Y | N |
| **Angina** | Y | N | **Frequent Diarrhea** | Y | N | **Pain in Jaw Joints** | Y | N |
| **Arthritis/Gout** | Y | N | **Frequent Headaches** | Y | N | **Parathyroid Disease** | Y | N |
| **Artificial Heart Valve** | Y | N | **Genital Herpes** | Y | N | **Psychiatric Care** | Y | N |
| **Artificial Joint** | Y | N | **Glaucoma** | Y | N | **Radiation Treatments** | Y | N |
| **Asthma** | Y | N | **Hay Fever** | Y | N | **Recent Weight Loss** | Y | N |
| **Blood Disease** | Y | N | **Heart Attack/Failure** | Y | N | **Renal Dialysis** | Y | N |
| **Blood Transfusion** | Y | N | **Heart Murmur** | Y | N | **Rheumatic Fever** | Y | N |
| **Breathing Problems** | Y | N | **Heart Pacemaker** | Y | N | **Rheumatism** | Y | N |
| **Bruise Easily** | Y | N | **Heart Trouble/Disease** | Y | N | **Scarlet Fever** | Y | N |
| **Cancer** | Y | N | **Hemophilia** | Y | N | **Shingles** | Y | N |
| **Chemotherapy** | Y | N | **Hepatitis A** | Y | N | **Sickle Cell Disease** | Y | N |
| **Chest Pains** | Y | N | **Hepatitis B or C** | Y | N | **Sinus Trouble** | Y | N |
| **Cold Sores/Blisters** | Y | N | **Herpes** | Y | N | **Spina Bifida** | Y | N |
| **Congenital Heart Disorder** | Y | N | **High Blood Pressure** | Y | N | **Stomach/Intestine Disease** | Y | N |
| **Convulsions** | Y | N | **High Cholesterol** | Y | N | **Stroke** | Y | N |
| **Cortisone Medicine** | Y | N | **Hives or Rash** | Y | N | **Swelling of Limbs** | Y | N |
| **Diabetes** | Y | N | **Hypoglycemia** | Y | N | **Thyroid Disease** | Y | N |
| **Drug Addiction** | Y | N | **Irregular Heartbeat** | Y | N | **Tonsillitis** | Y | N |
| **Easily Winded** | Y | N | **Kidney Problems** | Y | N | **Tuberculosis** | Y | N |
| **Emphysema** | Y | N | **Leukemia** | Y | N | **Tumors or Growths** | Y | N |
| **Epilepsy/Seizures** | Y | N | **Liver Disease** | Y | N | **Ulcers** | Y | N |
|  | Y | N |  | Y | N | **Venereal Disease** | Y | N |
| **Have you ever had any serious illness not listed above** | Y | N |  |   |   |
| **Comments:** |   |   |   |   |   |   |   |   |
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| **To the best of my knowledge, the questions on this form have been accurately answered. I understand the 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 my medical status.** |

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| **Signature of Patient, Parent or Guardian:****X Date:** |