

Name: \_\_\_\_\_ Dob \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Health problems you may have, or medications you're taking, could have a major interrelationship with the dentistry you'll receive. The following questions will ensure that we provide you with accurate care during your visit.

- |  |     |    |                        |
|--|-----|----|------------------------|
| Are you under a doctor's care now? (Provide Dr Name)         | Yes | No | If yes, explain: _____ |
| Have you ever been hospitalized or had a major operation?    | Yes | No | If yes, explain: _____ |
| Have you ever had a serious head or neck injury?             | Yes | No | If yes, explain: _____ |
| Are you taking any medications or supplements? (please list) | Yes | No | If yes, explain: _____ |
| Do you take or have taken Phen-Fen or Redux?                 | Yes | No | If yes, explain: _____ |
| Have you ever taken Fosamax/Bisphosphonates?                 | Yes | No | If yes, explain: _____ |
| Do you use controlled substances?                            | Yes | No | If yes, explain: _____ |
| Are you on a special diet?                                   | Yes | No | If yes, explain: _____ |
| Do you use tobacco?  | Yes | No | If yes, explain: _____ |

Notes or additional information provided: \_\_\_\_\_

**Women: Are you....**

- Pregnant or trying to conceive?
- Nursing?
- Taking oral contraceptives?

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

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other (please describe below):
<input type="checkbox"/> Latex	
<input type="checkbox"/> Codeine	
<input type="checkbox"/> Sulfa Drugs	

**Have you had or had any of the following symptoms?**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV                  | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Alzheimer                 | <input type="checkbox"/> Drug addiction            | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Scarlet fever              |
| <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hives or rash         | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Arthritis/Gout            | <input type="checkbox"/> Excessive bleeding        | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Spina bifida               |
| <input type="checkbox"/> Artificial heart valve    | <input type="checkbox"/> Excessive thirst          | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial joint          | <input type="checkbox"/> Fainting spells/dizziness | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Frequent cough            | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Swelling of limbs          |
| <input type="checkbox"/> Blood disease             | <input type="checkbox"/> Frequent diarrhea         | <input type="checkbox"/> Low blood pressure    | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood transfusion         | <input type="checkbox"/> Frequent headaches        | <input type="checkbox"/> Lung disease          | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Breathing problems        | <input type="checkbox"/> Genital Herpes            | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Tumors or growths          |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Hay fever                 | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Parathyroid disease   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chest pains               | <input type="checkbox"/> Heart murmur              | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Yellow Jaundice            |
| <input type="checkbox"/> Cold sores/fever blisters | <input type="checkbox"/> Heart pacemaker           | <input type="checkbox"/> Radiation treatments  |   |
| <input type="checkbox"/> Congenital heart disorder | <input type="checkbox"/> Heart trouble/disease     | <input type="checkbox"/> Recent weight loss    |   |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hemophilia                | <input type="checkbox"/> Renal Dialysis        |   |
| <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Hepatitis A               | <input type="checkbox"/> Rheumatic fever       |   |

If you have marked any of the above illnesses, please explain: \_\_\_\_\_

**Authorization**

To my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information may be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Name: \_\_\_\_\_

Signature of the patient, parent or guardian: \_\_\_\_\_

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_