

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? | <input type="radio"/> Yes <input type="radio"/> No | If yes <input type="text"/> |
| Have you ever been hospitalized or had a major operation? | <input type="radio"/> Yes <input type="radio"/> No | If yes <input type="text"/> |
| Have you ever had a serious head or neck injury? | <input type="radio"/> Yes <input type="radio"/> No | If yes <input type="text"/> |
| Are you taking any medications, pills, or drugs? | <input type="radio"/> Yes <input type="radio"/> No | If yes <input type="text"/> |
| Are you taking any supplements or herbals? | <input type="radio"/> Yes <input type="radio"/> No | If yes <input type="text"/> |
| Do you take, or have you taken, Phen-Fen or Redux? | <input type="radio"/> Yes <input type="radio"/> No | If yes <input type="text"/> |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | <input type="radio"/> Yes <input type="radio"/> No | If yes <input type="text"/> |
| Do you use tobacco? | <input type="radio"/> Yes <input type="radio"/> No | |

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

| | | | |
|----------------------------------|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Acrylic |
| <input type="checkbox"/> Metal | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Local Anesthetics |

Other? If yes

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

| | | | | | | | |
|------------------------|--|--------------------------------|--|-----------------------|--|-----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cold Sores | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimers Disease | <input type="radio"/> Yes <input type="radio"/> No | Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/failure | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Osteoperosis | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Heart trouble/disease | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Dialysis | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Easily winded/ Short of Breath | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problems | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy | <input type="radio"/> Yes <input type="radio"/> No | Hives/Rash | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disorder | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Kidney Disease | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy/Radiation | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains/Angina | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Tumors/ Growths | <input type="radio"/> Yes <input type="radio"/> No | | |

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

Comments:

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| <input type="text"/> |
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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: _____