

Patient's Name: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter-relationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes	_____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes	_____
Do your gums bleed, feel tender or irritated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?	_____
Are you nervous about dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes	_____
Did you take, or have you taken, Phen-Fen or Redux?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes	_____
Are you unhappy with the appearance of your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no	_____
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes	_____
Are your teeth sensitive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	if yes, to what?	____ HOT ____ COLD ____ PRESSURE

Women: Are you...

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

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"/> Local Anesthetics
<input type="checkbox"/> Sulpha	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Other?	If yes _____

Are you taking any Medications? ☐ Yes ☐ No If any, please list _____

Please check any of the following conditions that apply to you:

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attach/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles | |

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

Comments: _____

Consent: 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.

Patient Signature (parent if minor)

Date

Doctors Signature

Date

Doctors Signature

Date