Patient Name: _____ Date Created: _____

Are you under a physician's Care now?	☐ YES ☐ NO	Who is your provider?_____
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 you taking any medications?	☐ 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 any other medications containing bisphosphonates?	☐ YES ☐ NO	If yes_____
Are you on a special diet?	☐ YES ☐ NO	
Do you use tobacco?	☐ YES ☐ NO	

WOMEN: Are you……

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

Are you ALLERGIC to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other _____

Do you use controlled substances? ☐ Yes If Yes _____

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

AIDs/ HIV	☐ YES	Cortisone Medicine	☐ YES	Hemophilia	☐ YES	Radiation Treatments	☐ YES
Alzheimer's Disease	☐ YES	Diabetes	☐ YES	Hepatitis A	☐ YES	Recent Weight Loss	☐ YES
Anaphylaxis	☐ YES	Drug Addiction	☐ YES	Hepatitis B or C	☐ YES	Renal Dialysis	☐ YES
Anemia	☐ YES	Easily Winded	☐ YES	Herpes	☐ YES	Rheumatic Fever	☐ YES
Angina	☐ YES	Emphysema	☐ YES	High Blood Pressure	☐ YES	Rheumatism	☐ YES
Arthritis/ GOUT	☐ YES	Epilepsy/ Seizures	☐ YES	High Cholesterol	☐ YES	Scarlet Fever	☐ YES
Artificial Heart Valve	☐ YES	Excessive Bleeding	☐ YES	Hives or Rash	☐ YES	Shingles	☐ YES
Artificial Joint	☐ Yes	Excessive Thirst	☐ Yes	Hypoglycemia	☐ Yes	Sickle Cell Disease	☐ Yes
Asthma	☐ YES	Fainting Spells/ Dizziness	☐ YES	Irregular Heartbeat	☐ YES	Sinus Trouble	☐ YES
Blood Disease	☐ YES	Frequent Cough	☐ YES	Kidney Problems	☐ YES	Spina Bifida	☐ YES
Blood Transfusion	☐ YES	Frequent Diarrhea	☐ YES	Leukemia	☐ YES	Stomach/ Intestinal Disease	☐ YES
Breathing Problems	☐ YES	Frequent Headache	☐ YES	Liver Disease	☐ YES	Stroke	☐ YES
Bruise Easily	☐ YES	Genital Herpes	☐ YES	Low Blood Pressure	☐ YES	Swelling of Limbs	☐ YES
Cancer	☐ YES	Glaucoma	☐ YES	Lung Disease	☐ YES	Thyroid Disease	☐ YES
Chemotherapy	☐ YES	Hay Fever	☐ YES	Mitral Valve Prolapse	☐ YES	Tonsilitis	☐ YES
Chest Pains	☐ YES	Heart Attack/ Failure	☐ YES	Osteoporosis	☐ YES	Tuberculosis	☐ YES
Cold Sores/ Fever Blisters	☐ YES	Heart Murmur	☐ YES	Pain in Jaw Joints	☐ YES	Tumors or Growths	☐ YES
Congenital Heart Disorder	☐ YES	Heart Pacemaker	☐ YES	Parathyroid Disease	☐ YES	Ulcers	☐ YES
Convulsions	☐ YES	Heart Trouble/ Disease	☐ YES	Psychiatric Care	☐ YES	Venereal Disease	☐ YES
Serious Illness Not Listed:						Yellow Jaundice	☐ YES

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: _____ Date: _____