

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