Updated New Default 10/20/15

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 that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for

Do you currently have a primary care physician? Who are you seeing?	◉ Yes ○ No	If yes
Are you under a physician's care now? Who are you seeing? For what?	○ Yes ◉ No	If yes
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, drugs, vitamins or supplements?	◉ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you currently take medication for erectile dysfunction?	◉ Yes ○ No	If yes
Are you on a special diet? What kind?	○ Yes ◉ No	If yes
Do you use tobacco? What kind? How often?	◉ Yes ○ No	If yes
Do you use controlled substances? Which ones?	○ Yes ◉ No	If yes
Have you ever had a sleep study? When? What was your diagnoses? How is it treated?	○ Yes ◉ No	If yes

Women: Are you....

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

Are you allergic to any of the following?

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

Other? ☐ If yes

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

☐ AIDS/HIV	☐ Drug Addiction	☐ Hemophilia	☐ Psychiatric Care
☐ Alzheimers Disease	☐ Easily Winded	☐ Hepatitis A	☐ Radiation Treatments
☐ Anaphylaxis	☐ Eating Disorder	☐ Hepatitis B	☐ Recent Weight Loss
☐ Angina	☐ Emphysema	☐ Hepatitis C	☐ Renal Dialysis
☐ Arthritis	☐ Epilepsy/Seizures	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ High Cholesterol	☐ Rheumatism
☐ Artificial Joint	☐ Excessive Thirst	☐ Hives or Rash	☐ Scarlet Fever
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Hypoglycemia	☐ Shingles
☐ Blood Disease	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Bleeding Disorder	☐ Frequent Diarrhea	☐ Kidney Problems	☐ Sleep Apnea
☐ Breathing Problems	☐ Frequent Headaches	☐ Leukemia	☐ STD
☐ Bruise Easily	☐ Glaucoma	☐ Liver Disease	☐ Stomach/Intestinal Disease
☐ Cancer	☐ Gout	☐ Low Blood Pressure	☐ Stroke
☐ Chemotherapy	☐ Hay Fever	☐ Low Testosterone	☐ Swelling of Limbs
☐ Chest Pains	☐ Heart Attack/Failure	☐ Lung Disease	☐ Thyroid Disease
☐ Cold Sores/Herpes Type I	☐ Heart Arrythmia	☐ Mitro-Valve Prolapse	☐ Tonsillitis
☐ Congenital Heart Disorder	☐ Heart Murmur	☐ Osteoporosis	☐ Tuberculosis
☐ Cortisone Medicine	☐ Heart Pace Maker	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Diabetes Type I	☐ Heart Trouble/Disease	☐ Parathyroid Disease	☐ Ulcers
☐ Diabetes Type II			

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

Comments:

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:_____