

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? 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
- Do you use tobacco? Yes No
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes
- Do you use controlled substances? Yes No If yes
- Are you taking any medications, pills, or drugs? 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 Allergy? If yes

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

Have you had a joint replacement? If yes, type and date placed. Yes No If yes

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

- | | | | |
|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Ulcers <input type="radio"/> Yes <input type="radio"/> No | Hep A, B or C <input type="radio"/> Yes <input type="radio"/> No | Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No |
| Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Cold Sores / Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No |
| Stroke <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Leukemia <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Arthritis / Gout <input type="radio"/> Yes <input type="radio"/> No |
| Hives / Rash <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | High Cholestral <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No |
| Rheumatism <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No | Angina / Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Heart Attack / Failure <input type="radio"/> Yes <input type="radio"/> No |
| Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Depression <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No |
| Heart Trouble / Disease <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No | Anxiety <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Cancer <input type="radio"/> Yes <input type="radio"/> No |
| Dementia <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/ Dizziness <input type="radio"/> Yes <input type="radio"/> No | Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Breathing Problems <input type="radio"/> Yes <input type="radio"/> No |
| Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Bruises Easily <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No |
| Emphysema <input type="radio"/> Yes <input type="radio"/> No | Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | History of Medication Addiction <input type="radio"/> Yes <input type="radio"/> No | Anemia <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 | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | Drug Usage <input type="radio"/> Yes <input type="radio"/> No |
| Bleeding Problems <input type="radio"/> Yes <input type="radio"/> No | Heart Valve - Artificial <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Stomach / Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| AIDS/ HIV Positive / Exposure <input type="radio"/> Yes <input type="radio"/> No | | | |

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: _____