

Name: _____

DOB: _____

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 interrelationship with the dentistry you will receive. Thank you for answering the following questions.

MEDICAL HISTORY

Are you under a physician's care now? Doctor's name? 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, pills, or drugs? Yes No If yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes: _____

Do you use tobacco? Yes No

Are you:

Pregnant/ Trying to get pregnant? Nursing? Taking Oral Contraceptives?

Are you allergic to any of the following? Do you have any allergies? Please list: _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other: _____

Please CHECK if you have any of the following:

- | | | | | | |
|----------------------------|--|------------------------|--|----------------------|--|
| AIDS/HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Irregular Heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Alzheimer's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis/Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Trouble/Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anaphylaxis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach-Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Have you ever had any serious illness not listed above?

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.

X _____

Date: _____