Patient Name: _____ Birth Date: _____ Today's Date: _____

Are you under a physician's care now? ○Yes ○ No If yes, what _____

Have you ever been hospitalized or had a major operation? ○Yes ○ No If yes, what _____

Have you ever had a serious head or neck injury? ○Yes ○ No If yes, what_____

Are you taking any medications, pills or drugs? ○Yes ○ No If yes, please list _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○Yes ○ No

Do you use controlled substances? ○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 ❑Tetracycline

❑Metal ❑ Latex ❑Sulfa Drugs ❑Dental Anesthetics

❑Other? If yes, _____

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

AIDS/HIV Positive	○ Yes ○ No	Colitis	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Alcohol Abuse	○ Yes ○ No	Cong. Heart Disease	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Herpes	○ Yes ○ No	Radiation Treatment	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	Hives/Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sinus Problems	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Steroid Therapy	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Stomach/Int. Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting/Dizziness	○ Yes ○ No	Leukemia	○ Yes ○ No	Stroke	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Light Sensitivity	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Hay Fever	○ Yes ○ No	Liver Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cancer	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Lupus	○ Yes ○ No	Tumors/Growths	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Heart Disease	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Ulcers	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Valve Replace	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Cold Sores/F. Blisters	○ Yes ○ No	Hemophilia	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No		

Have you ever had any serious illness not listed above? ○Yes ○ No If yes, _____

Comments: _____

_____

_____

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

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