

Patient Name:	DOB:
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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.

	YES	NO
Are you under a physician's care now?		
Have you ever been hospitalized or had a major operation ?		
Have you ever had a serious head or neck injury?		
Are you taking any medications pills or drugs?		
Do you take or have you taken Phen-Fen or Redux?		
Have you ever taken Fosamax Boniva Actonel or any bisphosphonates?		
Are you on a special diet?		
Do you use tobacco?		
Women: Are you Pregnant / Trying to get pregnant or nursing ?	YES	NO

**Allergic to any of the following ? Circle any that apply.**

Latex	Metal	Acrylic	Asprin	Penicillin	Codeine	Sulfa Drugs	
Do you use any controlled substances or history of drug abuse?							
						YES	NO

Do you have any of the following:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Positive			Excessive Bleeding			Liver Disease		
Alzhiemers disease			Excessive Thirst			Low Blood Pressure		
Anaphylaxis			Fainting/Dizziness			Lung Disease		
Anemia			Frequent Cough			Mitral Valve Prolapse		
Angina			Frequent Headaches			Osteoporosis		
Arthritis / Gout			Glaucoma			Pain in Jaw Joints		
Artificial Heart Valve			Hay Fever			Parathyroid Disease		
Artificial Joint			Heart Attack/Failure			Radiation Treatments		
Asthma			Heart Murmur			Renal Dialysis		
Bloode disease			Heart Pacemaker			Rheumatic Fever		
Breathing problems			Heart Trouble/Disease			Rheumatism		
Cancer			Hepatitis A			Shingles		
Chemotherapy			Hepatitis B or C			Sickle Cell Disease		
Chest Pains			Herpes			Sinus Trouble		
Cold Sores/Blisters			High Blood Pressure			Stomach Disease		
Heart Disease			High Cholesterol			Stroke		
Cortisone medications			Hypoglycemia			Thyroid Disease		
Diabetes			Irregular Heartbeat			Tonsillitis		
Emphysema			Kidney Problems			Tuberculosis		
Epilpsey / Seizures			Leukemia			Tumors or Growths		

**Please List medications:**

Signature of patient or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_