Patient Name:_____ **Date of Birth:**_____

Although dental personnel primarily trat 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 can affect your oral health

Are you under a physicians care now for something specific such as: a cardiologist, Oncologist, etc. *If yes, who and what for:*	O Yes O No
Have you ever been hospitalized or had a major operation? *If yes, when and what for:*	O Yes O No
Have you ever had a serious head or neck injury? *If yes, when and what for:*	O Yes O No
Are you taking any medications, pills, or drugs? *If yes, when and what for:*	O Yes O No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No
Are you on a special diet?	O Yes O No
Do you use tobacco?	O Yes O No
Do you require Antibiotics prior to dental procedures?	O Yes O No

Women, are you? **O Pregnant/trying to get pregnant? O Nursing? O Taking oral contraceptives?**

Are you allergic to any of the following?

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

O Other:_____

Do you use controlled substances?	O Yes O No

Do you have or have you had any of the following:

AIDS/HIV Positive	O Yes	**Cortisone Meds**	O Yes	**Hemophilia**	O Yes	**Radiation Treatment**	O Yes
Alzheimer's disease	O Yes	**Diabetes**	O Yes	**Hepatitis A**	O Yes	**Recent Weight Loss**	O Yes
Anaphylaxis	O Yes	**Drug Addiction**	O Yes	**Hepatitis B/C**	O Yes	**Renal Dialysis**	O Yes
Anemia	O Yes	**Easily Winded**	O Yes	**Herpes**	O Yes	**Rheumatic Fever**	O Yes
Angina	O Yes	**Emphysema**	O Yes	**High Blood Pressure**	O Yes	**Rheumatism**	O Yes
Arthritis/Gout	O Yes	**Epilepsy or seizures**	O Yes	**High Cholesterol**	O Yes	**Scarlet Fever**	O Yes
Artificial Joint	O Yes	**Excessive Thirst**	O Yes	**Hypoglycemia**	O Yes	**Sickle Cell Disease**	O Yes
Asthma	O Yes	**Fainting spells or dizziness**	O Yes	**Irregular Heartbeat**	O Yes	**Sinus Trouble**	O Yes
Blood disease	O Yes	**Frequent cough**	O Yes	**Kidney Problems**	O Yes	**Spina Bifida**	O Yes
Blood Transfusion	O Yes	**Frequent Diarrhea**	O Yes	**Leukemia**	O Yes	**Stomach/ Intestinal Disease**	O Yes
Breathing problems	O Yes	**Frequent Headaches**	O Yes	**Liver Disease**	O Yes	**Stroke**	O Yes
Bruise Easily	O Yes	**Genital Herpes**	O Yes	**Low Blood Pressure**	O Yes	**Swelling of limbs**	O Yes
Cancer	O Yes	**Glaucoma**	O Yes	**Lung disease**	O Yes	**Thyroid Disease**	O Yes
Chemotherapy	O Yes	**Hay Fever**	O Yes	**Mitral Valve prolapse**	O Yes	**Tonsilitis**	O Yes
Chest Pains	O Yes	**Heart Attack/ Failure**	O Yes	**Osteoporosis**	O Yes	**Tuberculosis**	O Yes
Cold Sore/ Fever Blisters	O Yes	**Heart Murmur**	O Yes	**Pain in Jaw Joints**	O Yes	**Tumors or growths**	O Yes
Congenital Heart Disorder	O Yes	**Heart Pacemaker**	O Yes	**Parathyroid Disease**	O Yes	**Ulcers**	O Yes
Convulsions	O Yes	**Heart Trouble/ Disease**	O Yes	**Psychiatric Care**	O Yes	**Venereal Disease**	O Yes
Yellow Jaundice	O Yes	Have you had a serious illness not listed above?: O Yes:_____					

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 9or patient's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ **Date:** _____