Patient Name_____ Birth Date_____

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.

Are you under a physician's care now? O YES O NO If yes, please explain:_____
Have you ever been hospitalized or had a major operation? O YES O NO If yes, please explain:_____
Have you ever had a serious head or neck injury? O YES O NO If yes, please explain:_____
Are you taking any medications, pills, or drugs? O YES O NO If yes, please explain:_____
Are you on a special diet? O YES O NO If yes, please explain:_____
Do you use tobacco? O YES O NO If yes, please explain:_____
Do you use controlled substances? O YES O NO If yes, please explain:_____

Women: Are you
Pregnant/Trying to get pregnant? O YES O NO Taking oral contraceptives? O YES O NO Nursing? O YES O NO

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex O Sulfa drugs
O Other If yes, please explain:_____

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

O AIDS/HIV Positive	O Cortisone Medicine	O Hemophilia	O Radiation Treatments
O Alzheimer's Disease	O Diabetes	O Hepatitis A	O Recent Weight Loss
O Anaphylaxis	O Drug Addiction	O Hepatitis B or C	O Renal Dialysis
O Anemia	O Easily Winded	O Herpes	O Rheumatic Fever
O Angina	O Emphysema	O High Blood Pressure	O Rheumatism
O Arthritis/Gout	O Epilepsy or Seizures	O High Cholesterol	O Scarlet Fever
O Artificial Heart Valve	O Excessive Bleeding	O Hives or Rash	O Shingles
O Artificial Joint	O Excessive Thirst	O Hypoglycemia	O Sickle Cell Disease
O Asthma	O Fainting Spells/Dizziness	O Irregular Heartbeat	O Sinus Trouble
O Blood Disease	O Frequent Cough	O Kidney Problems	O Stomach/Intestinal Disease
O Blood Transfusion	O Frequent Diarrhea	O Leukemia	O Stroke
O Breathing Problem	O Frequent Headaches	O Liver Disease	O Swelling of Limbs
O Bruise Easily	O Genital Herpes	O Low Blood Pressure	O Thyroid Disease
O Cancer	O Glaucoma	O Lung Disease	O Tonsillitis
O Chemotherapy	O Hay Fever	O Mitral Valve Prolapse	O Tuberculosis
O Chest Pains	O Heart Attack/Failure	O Osteoporosis	O Tumors or Growths
O Cold Sores/Fever Blisters	O Heart Murmur	O Pain in Jaw Joints	O Ulcers
O Congenital Heart Disorder	O Heart Pacemaker	O Parathyroid Disease	O Venereal Disease
O Convulsions	O Heart Trouble/Disease	O Psychiatric Care	O Yellow Jaundice

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:_____ Date:_____