PATIENT NAME______________________________

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.

Physician's Name______________________ Address______________________ Phone #__________

Pharmacy of Choice ______________________ Phone______________________

Are you under a physician's care now? ❍ Yes ❍ No ❍ Explain__________

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No ❍ Explain__________

Have you ever had a serious head or neck injury? ❍ Yes ❍ No ❍ Explain__________

Have you ever had radiation treatment? When? ________

Do you use alcohol? ❍ Yes ❍ No ❍ How Much __________

Do you use tobacco? ❍ Yes ❍ No ❍ Explain__________

Do you use controlled substances? ❍ Yes ❍ No ❍ Explain__________

Are you on a special diet? ❍ Yes ❍ No ❍ Explain__________

Do you take, or have you taken, Phen-Fen, Redux or diet pills? ❍ Yes ❍ No ❍ Explain__________

Are you taking any medications, pills, drugs, or herbal supplement? ❍ Yes ❍ No ❍ Explain__________

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Have you ever been told you **need to Pre Medicate** prior to dental appointment? ❍ Yes ❍ No ❍ Explain __________

Check box (es) if you have or have had any of the following

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

Any other illness not listed above:______________________

Medications: ______________________

Have you ever had any serious illness not listed above ❍ Yes ❍ No ❍ N/A __________

Comments: ______________________

*Condition may require medication N/A - Not answered by patient

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.

DR.'S SIGNATURE ______________________

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE __________