Are you under a physicians care? Yes No If yes, who _____

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

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

Are you taking any medications, pills, or drugs? Yes No If yes, what _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, what _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes No If yes, what _____

Are you on a special diet? Yes No Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes, what _____

Women- Are you … ○ Pregnant/trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs ☐ Local Anesthetics

Other allergy _____

Do you have or *have you had* any of the following? ***(Please mark yes or no for every statement)***

Aids/HIV Positive	Yes No	Excessive Thirst	Yes No	Mitral Valve Prolapse	Yes No
Alzheimer's Disease	Yes No	Fainting Spells/Dizziness	Yes No	Osteoporosis	Yes No
Anaphylaxis	Yes No	Frequent Cough	Yes No	Pain in Jaw Joints	Yes No
Anemia	Yes No	Frequent Diarrhea	Yes No	Parathyroid Disease	Yes No
Angina	Yes No	Frequent Headaches	Yes No	Psychiatric Care	Yes No
Arthritis/Gout	Yes No	Genital Herpes	Yes No	Radiation Treatments	Yes No
Artificial Heart Valve	Yes No	Glaucoma	Yes No	Recent Weight Loss	Yes No
Artificial Joint	Yes No	Hay Fever	Yes No	Renal Dialysis	Yes No
Asthma	Yes No	Heart Attack/Failure	Yes No	Rheumatic Fever	Yes No
Blood Disease	Yes No	Heart Murmur	Yes No	Rheumatism	Yes No
Blood Transfusion	Yes No	Heart Pacemaker	Yes No	Scarlet Fever	Yes No
Breathing Problems	Yes No	Heart Trouble/Disease	Yes No	Shingles	Yes No
Bruise Easily	Yes No	Hemophilia	Yes No	Sickle Cell Disease	Yes No
Cancer	Yes No	Hepatitis A	Yes No	Sinus Trouble	Yes No
Chemotherapy	Yes No	Hepatitis B or C	Yes No	Spina Bifida	Yes No
Chest Pains	Yes No	Herpes	Yes No	Stomach/Intestinal Disease	Yes No
Cold Sores/Fever Blisters	Yes No	High Blood Pressure	Yes No	Stroke	Yes No
Congenital Heart Disorder	Yes No	High Cholesterol	Yes No	Swelling of Limbs	Yes No
Convulsions	Yes No	Hives or Rash	Yes No	Thyroid Disease	Yes No
Cortisone Medicine	Yes No	Hypoglycemia	Yes No	Tonsillitis	Yes No
Diabetes	Yes No	Irregular Heartbeat	Yes No	Tuberculosis	Yes No
Drug Addiction	Yes No	Kidney Problems	Yes No	Tumors or growths	Yes No
Easily Winded	Yes No	Leukemia	Yes No	Ulcers	Yes No
Emphysema	Yes No	Liver Disease	Yes No	Venereal Disease	Yes No
Epilepsy or Seizures	Yes No	Low Blood Pressure	Yes No	Yellow Jaundice	Yes No
Excessive Bleeding	Yes No	Lung Disease	Yes No		

Any other serious illness not listed above? Yes No If yes, what _____

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 of Patient, Parent, or Guardian _____ Date _____