

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 you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Last Name: _____ First Name: _____ MI: _____ Birthdate: _____

Are you under a physician's care now? Yes: No: If Yes, who?: _____

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

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Tetracycline
 Milk Products Other _____

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

	Yes	No		Yes	No		Yes	No
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Conditions	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____ Year: _____			High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>

Do you have a neurological disorder such as?

Myasthenia Gravis (MA)
 Amyotrophic lateral sclerosis (ALS)
 Lambert Eaton Syndrome

Women, are you:

Pregnant
 Trying to get pregnant
 Nursing
 Taking oral contraceptives

Do you take blood thinners such as?

Aspirin
 Eliquis
 Xarelto
 Vitamin E
 Ginkgo Biloba
 St. John's Wort
 Ibuprofen/Motrin
 Aleve
 Vioxx
 Other: _____

Have you ever used bisphosphonates?
 (ie.Fosamax, Boniva)

Do you have heart issues?

Artificial (prosthetic) heart valve
 Previous infective endocarditis
 Damaged valves in transplanted heart
 Congenital heart disease (CHD)
 Unrepaired, cyanotic CHD
 Repaired (completely) in last 6 months
 Repaired CHD with residual defects
 Other: _____

Do you use?

Tobacco
 Smokeless tobacco
 Drugs

Are there any other medical conditions not listed above? Yes: No: If Yes, explain: _____

Preferred Pharmacy:

Name: _____ Phone #: _____ Location: _____

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.

Patient (or Parent/Guardian) Signature: _____ Date: _____

Print Name: _____