

ID# _____

Patient Name (Please Print) _____ DOB _____ DATE _____

Medical issues or medications could have an important interrelationship with the dentistry that you may be receiving. Please complete thoroughly:

Physician's Name: _____ Phone #: _____ Last Exam: _____

Are you under physician's care now? Yes No If yes, please explain: _____

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

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

Are you taking any medications, pills, or drugs? Yes No If yes, please list all: _____

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

Have you ever taken Fosamax, Boniva, Acotnel or any other medications containing bisphosphonates? Yes No _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

List any non-prescription or over the counter products you're taking: _____

Women only:

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Allergies: (Please mark "No" if you have not had an allergic reaction or have not previously been exposed to the following)

Table with 4 columns of allergy types: Aspirin, Barbiturates, Codeine, Iodine, Latex, Local Anesthetics, Metals, Penicillin, Sedatives, Sulfa Drugs, Others.

Health Conditions/Concerns:

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Dental History/Concerns:

Table with 3 columns of dental concerns: Gums bleed while brushing or flossing, Tooth pain, Sores or lumps in or out of mouth, Previous difficult extractions, Any prolonged bleeding after extraction, How often do you brush your teeth?, Previous orthodontic treatment, Is Fluoride taken in any form, Mouth habits: nail biting, thumb sucking, Biting lips or cheeks frequently, Do you use an electric toothbrush, How often do you floss?, Tooth sensitivity to hot or cold, Tooth sensitivity to sweet or sour, Clenching or grinding teeth, Difficulty with chewing, Is there anything you would like to change about your smile?

Acknowledgement:

No

Office Use Only: ♥ Blood Pressure: / Pre-Med Status: Yes

To the best of my knowledge, the above questionnaire has been answered accurately. I understand that providing incorrect information can be dangerous to my (or the patients) health. I also understand that it is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Guardian

Date

Signature of Dentist

Date