Although dental personnel primarily treat 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 thoroughly answering the following questions.

MEDICAL HISTORY

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

Have you ever been hospitalized or had major surgeries?
Yes No If yes, please explain: ______________________

Have you ever had serious head or neck injuries?
Yes No If yes, please explain: ______________________

Are you currently taking any medications?
Yes No If yes, please explain: ______________________

Do you take or have you take Phen-fen or Redux?
Yes No If yes, please explain: ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates?
Yes No If yes, please explain: ______________________

Are you on a special diet? Yes No
Do you use controlled substances? Yes No
Do you use tobacco? Yes No
How often? ______________

Women: (Please Circle)
Pregnant? Yes No Nursing? Yes No
Taking oral contraceptives? Yes No

Are you allergic to any of the following? (Please Circle)

Asprin Penecillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs Other:

If yes, please explain: ______________________

Do you , or have you had any of the following? If yes, please explain: ______________________

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

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:**__________