Name: ______________________ **Date:** ______________

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.

Dental information

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

Question		
Gums Bleed when you brush or floss?	Yes	No
Is your mouth dry?	Yes	No
Have you ever had braces?	Yes	No
Is your home water supply fluoridated?	Yes	No
Experiencing dental pain or discomfort?	Yes	No
Clicking or discomfort in the jaw?	Yes	No
Sores or ulcers in your mouth?	Yes	No
Serious injury to head or mouth?	Yes	No
Are your teeth sensitive?	Yes	No
Have you had any periodontal treatments?	Yes	No
Problems with previous dental treatment?	Yes	No
Do you have earaches or neck pains?	Yes	No
Do you brux or grind your teeth?	Yes	No
Do you wear dentures or partials?	Yes	No

Date of your last dental exam: ______________

Date of last dental x-rays: ______________

What is the reason for your dental visit today?

____

Medical information

Question				
Are you under a physician's care now?	Yes	No	If yes	
Have you ever been hospitalized	Yes	No	If yes	
Had a major operation?	Yes	No	If yes	
Are you taking any medications or do you require a premedication for dental visits?	Yes	No	Please list	
Are you taking any controlled substances?	Yes	No	Please list	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphates?	Yes	No	If yes	
Are you on a special diet?	Yes	No	If yes	
Do you use tobacco?	Yes	No	If yes	

Continue to next page please.....

Medical information continued

Women: Are you:

○ Pregnant? ○ Nursing? ○ Taking contraceptives?

Are you allergic to any of the following?:

○ Aspirin	○ Penicillin	○ Codeine	○ Acrylic
○ Metal	○ Latex	○ Sulfa Drugs	○ Local Anesthetics

Other? ○ If yes ______

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

Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	○ Yes	○ No	Hemophilia	○ Yes	○ No
Alzheimer's Disease	○ Yes	○ No	Hepatitis A, B or C	○ Yes	○ No
Drug Addiction	○ Yes	○ No	Anemic	○ Yes	○ No
Rheumatic Fever	○ Yes	○ No	Emphysema	○ Yes	○ No
Arthritis/Gout/Rheumatism	○ Yes	○ No	High Cholesterol	○ Yes	○ No
Excessive Bleeding/Bruise easily	○ Yes	○ No	Artificial Joint	○ Yes	○ No
Hypoglycemia	○ Yes	○ No	Asthma	○ Yes	○ No
Irregular Heartbeat	○ Yes	○ No	Frequent Cough	○ Yes	○ No
Spina Bifida	○ Yes	○ No	Stomach/Intestinal Disease	○ Yes	○ No
Stroke	○ Yes	○ No	Swelling of Limbs	○ Yes	○ No
Glaucoma	○ Yes	○ No	Chest Pains	○ Yes	○ No
Seasonal Allergies	○ Yes	○ No	Cold Sores/ Frever Blisters	○ Yes	○ No
Osteoporosis	○ Yes	○ No	Parathyroid or Thyroid Disease	○ Yes	○ No
Congenital Heart Disorder	○ Yes	○ No	Lupus	○ Yes	○ No
Psychiatric Care	○ Yes	○ No	Radiation Treatment	○ Yes	○ No
Cortisone Medicine	○ Yes	○ No	Anaphylaxis	○ Yes	○ No
Diabetes	○ Yes	○ No	Easily Winded, Breathing problems	○ Yes	○ No
Renal Dialysis	○ Yes	○ No	High Blood Pressure	○ Yes	○ No
Angina	○ Yes	○ No	Artificial Heart Valve	○ Yes	○ No
Epilepsy or Seizures	○ Yes	○ No	Excessive Thirst	○ Yes	○ No
Shingles	○ Yes	○ No	Fainting Spells/ Dizziness	○ Yes	○ No
Sickle Cell Disease	○ Yes	○ No	Kidney Disease	○ Yes	○ No
Sinus Trouble	○ Yes	○ No	Liver Disease	○ Yes	○ No
Leukemia	○ Yes	○ No	Cancer/Tumors	○ Yes	○ No
Low Blood Pressure	○ Yes	○ No	Chemotherapy	○ Yes	○ No
Lung Disease	○ Yes	○ No	Heart Attack/ Failure	○ Yes	○ No
Mitral Valve Prolapse	○ Yes	○ No	Heart Murmur	○ Yes	○ No
Tuberculosis	○ Yes	○ No	Heart Trouble/ Disease	○ Yes	○ No
Pacemaker	○ Yes	○ No	Eating Disorder	○ Yes	○ No
GE Reflux/ Persistent Heartburn	○ Yes	○ No			

Have you ever had any serious illness not listed above? ○ Yes ○ No

If yes ______

Comments:

______

To the best if 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 charges in medical status.

Signature of Patient, Parent, or Guardian: ______ Date: ______