Patient Name: ______________________________ **Birth Date:** ________________

Although dental personnel primarily treat the area in and around your mouth health problems that you may have, or medication you are taking could have an important interrelationship with the dental care you receive. Thank you for answering the questions to the best of your ability.

Are you under a physcians care now? If YES, please explain: ________________

Have you ever been hospitalized or had a major operation? If YES, please explain: ________________

Have you ever had a serious head or neck injury? If YES, please explain: ________________

Are you taking any medications, controlled substances or supplements? If so please list below with dosage and frequency:

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

Do you take or have you ever taken Fosamax, Actonel, or Biphosphonate (used to treat osteoporosis/Paget's disease): **[ ] Y [ ] N**

Do you use tobacco products? [ ] Y [ ] N If Yes, how frequently?________________

Women: Are you pregnant? [ ] **Y** [ ] **N** If **Yes**, # of weeks? ________ Est. Due Date: ________

Trying to get pregnant? [ ] **Y** [ ] **N** Are you taking oral contraceptives? [ ] **Y** [ ] **N**

ALLERGIES: *Are you allergic to any of the following? If so please **CIRCLE** them below*

Aspirin/NSAID/Motrin	Codiene	Penicillin/Amoxicilin/Augmentin	Metals
Acetaminophen(Tylenol)	Clindamycin	Sulfa (erythromycin/bactrim)	Acrylic
Barbituates or sedatives	Local Anesthetic	Latex (rubber)	

Foods, if so please list them : ________________

Please put any not listed above or explain ones circled above in detail. please do: ________________

Have or have you had any of the following? *If so please **CIRCLE** them below*

AIDS/HIV	Chronic pain	Heart murmur	Mental health disorders
Angina	Congenital heart disorder	Hemophilia	Mitral valve prolapse
Arthritis	Cortisone medicine	Hepatitis B	Pacemaker
Artifical heart valves	Diabetes	Hepatitis C	Sinus problems
Artificial Joint Replacement	Drug addiction	High Blood Pressure	Thyroid problems
Asthma	Emphysema	Hypoglycemia	Tonsillitis
Cancer / Chemotherapy	Epilepsy or Seizures	Kidney problems	Tuberculosis
Chest Pain	Fibromyalgia	Liver Disease	
Chronic heartburn	Heart Attack/Failure	Low Blood Pressure	

Have you ever had any serious illness not listed above? If yes, please state: ________________

If you circled any of the boxes above please explain below, such as years instances occurred, specifics about a condition, or explanations: ________________

To the best of my knowledge the questions on this form have been accurately answered. I understand providing incorrect information or omitting information may be dangerous to my health. It is my responsibility to inform staff of any changes to medical history or status.

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