First and Last Name: _____ Date of Birth: _____

Are you under a physicians care now? ☐Yes ☐No If Yes_____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No If Yes_____

Have you ever had a serious head or neck injury? ☐Yes ☐No If Yes_____

Are you taking any medications, pills, or drugs? ☐Yes ☐No If Yes_____

Do you use controlled substances? ☐Yes ☐No If Yes_____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No If Yes_____

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

If Yes_____

Have you received the HPV vaccine? ☐Yes ☐No

Do you suffer from acid reflux/GERD? ☐Yes ☐No

Do you (or has anyone ever told you that you) snore at night? ☐Yes ☐No

Do you feel well rested? ☐Yes ☐No

Are you on a special diet? ☐Yes ☐No

Do you use tobacco? ☐Yes ☐No

Are you allergic to any of the following?

☐ Aspirin	☐ Metal	☐ Acetaminophen	☐ Erythro	☐ Acrylic
☐ Penicillin	☐ Latex	☐ Iodine	☐ Clindamycin	
☐ Codeine	☐ Sulfa Drugs	☐ Amoxicillin	☐ Local Anesthetics	

☐ Other: _____

WOMEN: Are you…

☐ Trying to get pregnant? ☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐None

Do you have, or have you had, any of the following? (Yes/No)

Y N	Y N	Y N	Y N
☐☐ AIDS/HIV Positive	☐☐ Alzheimer's Disease	☐☐ Anaphylaxis	☐☐ Anemia
☐☐ Angina	☐☐ Arthritis	☐☐ Artificial Heart Valve	☐☐ Artificial Joint
☐☐ Asthma	☐☐ Back Problems	☐☐ Blood Disease	☐☐ Blood Transfusion
☐☐ Breathing Problems	☐☐ Bruise Easily	☐☐ Cancer	☐☐ Cardiovascular Disease
☐☐ Chemotherapy	☐☐ Chest Pains	☐☐ Cold Sores/Fever Blisters	☐☐ Congenital Heart Disorder
☐☐ Cortisone Medicine	☐☐ Dementia	☐☐ Depression/Anxiety	☐☐ Diabetes Type I
☐☐ Diabetes Type II	☐☐ Drug Addiction	☐☐ Easily Winded	☐☐ Emphysema
☐☐ Epilepsy or Seizures	☐☐ Excessive Bleeding	☐☐ Excessive Thirst	☐☐ Fainting Spells/Dizziness
☐☐ Frequent Cough	☐☐ Frequent Diarrhea	☐☐ Frequent Ear Aches	☐☐ Frequent Headaches
☐☐ Gastrointestinal Disease	☐☐ Glaucoma	☐☐ Gout	☐☐ Hay Fever
☐☐ Heart Attach/Failure	☐☐ Heart Murmur	☐☐ Heart Pacemaker	☐☐ Hemophilia
☐☐ Hepatitis A	☐☐ Hepatitis B or C	☐☐ High Blood Pressure	☐☐ High Cholesterol
☐☐ Hives or Rash	☐☐ Hypoglycemia	☐☐ HPV	☐☐ Immune Deficiency
☐☐ Irregular Heartbeat	☐☐ Kidney Disease	☐☐ Leukemia	☐☐ Liver Disease
☐☐ Low Blood Pressure	☐☐ Lung Disease	☐☐ Mitral Valve Prolapse	☐☐ Neurological Disorder
☐☐ Osteopenia	☐☐ 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	☐☐ Sleep Apnea
☐☐ Stomach Problems	☐☐ Stroke	☐☐ Swelling of Limbs	☐☐ Teeth Grinding/Clenching
☐☐ Thyroid Disease	☐☐ Tonsillitis	☐☐ Tuberculosis	☐☐ Tumors or Growths
☐☐ Ulcers	☐☐ Venereal Disease	☐☐ Yellow Jaundice	

Have you ever had a serious illness not listed above? _____

_____

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:

X _____ Date: _____