HOCKESSIN DENTAL
FAMILY & COSMETIC DENTISTRY

Patient Name:_____ DOB: _____ Date:_____

| | | | |
|---|---|---|---|
| Are you under a physician's care or being treated for any type of condition? | ○YES | ○ NO | If yes |
| Are you taking medications, pills, drugs, or controlled substances? | ○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 |
| 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 |
| Are you on a special diet? | ○YES | ○ NO | If yes |
| Do you use tobacco? If so, what frequency? | ○YES | ○ NO | If yes |

**Please check any that apply to you:**

☐ Do you or your family members suffer from sleep apnea?

☐ Do you snore loudly (louder than talking or heard through closed doors)?

☐ Do you often feel tired, fatigued, or sleepy during the daytime?

☐ Has anyone observed you stop breathing during your sleep?

☐ Do you have or are you being treated for high blood pressure?

**Women: Are you…**

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐ Trying to get pregnant?

**Are you allergic to any of the following?**

| | | | |
|---|---|---|---|
| ☐ Aspirin | ☐ Penicillin | ☐ Codeine | ☐ Acrylic |
| ☐ Metals | ☐ Latex | ☐ Sulfa Drugs | ☐ Local Anesthetics |
| **Other?** | ○ YES | ○ NO | If yes |

**Are you satisfied with your smile?** ○ YES ○ NO

**What would you like to change about your smile?**

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

| | | | | | |
|---|---|---|---|---|---|
| ADD/ADHD | ○ YES | ○ NO | Heart Murmur | ○ YES | ○ NO |
| AIDS/HIV Positive | ○ YES | ○ NO | Heart Pacemaker | ○ YES | ○ NO |
| Alzheimer's Disease | ○ YES | ○ NO | Heart Trouble/Disease | ○ YES | ○ NO |
| Anaphylaxis | ○ YES | ○ NO | Hemophilia | ○ YES | ○ NO |
| Anemia | ○ YES | ○ NO | Hepatitis B | ○ YES | ○ NO |
| Angina | ○ YES | ○ NO | Hepatitis C | ○ YES | ○ NO |
| Anxiety | ○ YES | ○ NO | Herpes | ○ YES | ○ NO |
| Arthritis/Gout | ○ YES | ○ NO | High Blood Pressure | ○ YES | ○ NO |
| Artificial Heart Valve | ○ YES | ○ NO | High Cholesterol | ○ YES | ○ NO |
| Artificial Joint | ○ YES | ○ NO | Hives or Rash | ○ YES | ○ NO |
| Asthma | ○ YES | ○ NO | Hypoglycemia | ○ YES | ○ NO |
| Blood Disease | ○ YES | ○ NO | Irregular Heartbeat | ○ YES | ○ NO |
| Blood Transfusion | ○ YES | ○ NO | Kidney Problems | ○ YES | ○ NO |
| Breathing Problems | ○ YES | ○ NO | Liver Disease | ○ YES | ○ NO |
| Bruise Easily | ○ YES | ○ NO | Low Blood Pressure | ○ YES | ○ NO |
| Cancer | ○ YES | ○ NO | Lung Disease | ○ YES | ○ NO |
| Cerebral Palsy | ○ YES | ○ NO | Osteoporosis | ○ YES | ○ NO |
| Chemotherapy | ○ YES | ○ NO | Pain in Jaw Joints | ○ YES | ○ NO |
| Chest Pains | ○ YES | ○ NO | Parathyroid Disease | ○ YES | ○ NO |
| Cold Sores/Fever Blisters | ○ YES | ○ NO | Psychiatric Care | ○ YES | ○ NO |
| Congenital Heart Disorder | ○ YES | ○ NO | Renal Dialysis | ○ YES | ○ NO |
| Cortisone Medicine | ○ YES | ○ NO | Rheumatic Fever | ○ YES | ○ NO |
| Diabetes | ○ YES | ○ NO | Rheumatism | ○ YES | ○ NO |
| Drug Addiction | ○ YES | ○ NO | Shingles | ○ YES | ○ NO |
| Easily Winded | ○ YES | ○ NO | Sickle Cell Disease | ○ YES | ○ NO |
| Emphysema | ○ YES | ○ NO | Sinus Trouble | ○ YES | ○ NO |
| Epilepsy or Seizures | ○ YES | ○ NO | Stomach/Intestinal Disease | ○ YES | ○ NO |
| Excessive Bleeding | ○ YES | ○ NO | Stroke | ○ YES | ○ NO |
| Fainting Spells/Dizziness | ○ YES | ○ NO | Swelling of the Limbs | ○ YES | ○ NO |
| Frequent Cough | ○ YES | ○ NO | Thyroid Disease | ○ YES | ○ NO |
| Frequent Headache | ○ YES | ○ NO | Tonsillitis | ○ YES | ○ NO |
| Glaucoma | ○ YES | ○ NO | Tuberculosis | ○ YES | ○ NO |
| Growths | ○ YES | ○ NO | Tumors | ○ YES | ○ NO |
| Hay Fever | ○ YES | ○ NO | Ulcers | ○ YES | ○ NO |
| Heart Attack/Failure | ○ YES | ○ NO | | | |

**Have you ever had any serious illness not listed above?**

**To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or the 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 _____