***MEDICAL***

Are you under a physician’s care right now? Yes or No If yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized, had a serious illness, or operation? Yes or No If yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a serious head or neck injury? Yes or No If yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications. Pills, or drugs? Yes or No If yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have well water? Yes or No

Do you use tobacco? Yes or No

Do you use controlled substances? Yes or No? If Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***BELOW PLEASE CIRCLE ANYTHING THAT APPLIES:***

WOMEN are you

Pregnant/trying to get pregnant Nursing Taking Oral Contraceptives

Are you allergic to the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Amoxicillin

Local Anesthetics Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***DO YOU HAVE ANY OF THE FOLLOWING (CIRCLE)***

AIDS/HIV Seasonal Allergies Alzheimer’s Angina (chest pain) Arthritis/Gout Artificial Heart Valve Artificial Joints Asthma Blood Disease Blood Transfusion Breathing Problems Chemotherapy

Chest Pains Congenital Heart Disorder Convulsions Cortisone Medications Diabetes Dizziness/Fainting Drug Addiction Emphysema Epilepsy/seizures Excessive Bleeding Glaucoma

Heart Conditions Heart Lesions Heart Surgery Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Hemophilia

High Blood Pressure High Cholesterol Hives or Rash Hepatitis A Hepatitis B or C Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease

Mitral Valve Prolapse Osteoporosis Parathyroid Disease Psychiatric Care

Anemia Radiation Treatments Rheumatic Fever Scarlet Fever

Shingles Sickle Cell Disease Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers

Venereal Disease Yellow Jaundice Antibiotic Premedication Cancer

Cold Sores/ Fever Blisters

***ANY SERIOUS ILLNESS NOT LISTED?*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***ARE YOU SENSITIVE TO ANY OF THE FOLLOWING?***

Hot Cold Sweet Pressure/Chewing

***DO YOU HAVE ANY OF THE FOLLOWING?***

Frequent Headaches Earaches Easily Winded Excessive Thirst

Frequent Cough Neck Pain Jaw Joint Pain Teeth/fillings Breaking

Grinding/Clenching Bad Breath Bleeding, Swollen or Irritated Gums

***SIGNATURE***

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_