



Today's Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____

Are you under a physician's care now? Yes No If so, for what? _____

Physician's Name _____ Phone # (_____) _____

Are you taking (or supposed to be taking) any medications, vitamins or herbal supplements? Yes No Please list below ↩

Are you pregnant? Yes No If yes, due date _____

Are you on a special diet? Yes No

Any digestive problems? Yes No

Do you use tobacco in any form? Yes No _____

Have you ever taken or are you currently taking any bisphosphonates such as Zometa, Fosamax, Aredia, Actonel, Boniva Didronel, Skelid, Bonefos, or alendronate? Yes No

Are you allergic to any medications or substances? Yes No If yes, please check boxes below.
 Aspirin Penicillin Sulfa Drugs Codeine
 Latex or Rubber Other _____

Have you ever had a reaction or experienced complications to any dental treatment in the past? Yes No

Please check "yes" if you presently have or have had in the past any of the following conditions:

Heart Trouble/Disease	<input type="checkbox"/>	Yes	Lung or Breathing Problems	<input type="checkbox"/>	Yes	Severe Headaches	<input type="checkbox"/>	Yes
Heart Murmur*	<input type="checkbox"/>		Shortness of Breath	<input type="checkbox"/>		Fainting or Dizzy Spells	<input type="checkbox"/>	
Irregular Heart Beat	<input type="checkbox"/>		Sinus Trouble	<input type="checkbox"/>		Epilepsy, Seizures or Convulsions	<input type="checkbox"/>	
Angina or Chest Pain	<input type="checkbox"/>		Asthma	<input type="checkbox"/>		Psychiatric Care	<input type="checkbox"/>	
Heart Attack or Failure	<input type="checkbox"/>		Chronic Cough	<input type="checkbox"/>		Hepatitis, Jaundice or Liver disease	<input type="checkbox"/>	
Congenital Heart Disorder	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>		Arthritis, Gout or Rheumatism	<input type="checkbox"/>	
Mitral Valve Prolapse*	<input type="checkbox"/>		Tuberculosis (TB)	<input type="checkbox"/>		Artificial Joint*	<input type="checkbox"/>	
Rheumatic Fever*	<input type="checkbox"/>		Frequent Sore Throat	<input type="checkbox"/>		Night Sweats	<input type="checkbox"/>	
Artificial Heart Valve*	<input type="checkbox"/>		Tumor or Cancer	<input type="checkbox"/>		Stomach or Intestinal Disease	<input type="checkbox"/>	
Heart Pacemaker*	<input type="checkbox"/>		X-ray or Cobalt Treatment	<input type="checkbox"/>		Thyroid Disease	<input type="checkbox"/>	
Heart Surgery	<input type="checkbox"/>		Chemotherapy	<input type="checkbox"/>		Kidney or Bladder Problems	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>		Enlarged Lymph Nodes (Glands)	<input type="checkbox"/>		Renal Dialysis	<input type="checkbox"/>	
Aneurysm	<input type="checkbox"/>		Swelling of Limbs	<input type="checkbox"/>		Hypoglycemia	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>		Bruise Easily	<input type="checkbox"/>		Frequent Diarrhea	<input type="checkbox"/>	
Low Blood Pressure	<input type="checkbox"/>		HIV Positive or AIDS	<input type="checkbox"/>		Glaucoma or Eye Problems	<input type="checkbox"/>	
Bleeding Disorder	<input type="checkbox"/>		Sexually Transmitted Diseases	<input type="checkbox"/>		Excessive Thirst	<input type="checkbox"/>	
Blood Transfusion	<input type="checkbox"/>		Major surgery	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	

Have you ever had any other disease, problem or condition not listed above? Yes No Discuss _____

Do you wish to speak privately to the dentist about any problems? Yes No

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.

Patient, Parent or Guardian Signature _____ Date _____