PATIENT NAME_____Birth date_____

Are you under a physician's care now? Y / N. If yes, please explain_____

Have you ever had a major operation? Y / N. If yes, please explain_____

Are you taking any medications? Y / N. If yes, please explain_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphanates? Y / N.

Do you use tobacco? Y / N

Women: Are you pregnant? Y / N. Taking oral contraceptives? Y / N.

Are you allergic to any of the following? Aspirin___, Penicillin___, Local Anesthetics___,Codeine___, Acrylic___ Metal___, Latex___, Sulfa drugs___, Other___, If yes, please explain_____

_____

__

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

AIDS/HIV Positive	Y / N	Drug Addiction	Y / N	Kidney Problems	Y / N
Alzheimer's Disease	Y / N	Epilepsy or Seizures	Y / N	Leukemia	Y / N
Anemia	Y / N	Excessive Bleeding	Y / N	Liver Disease	Y / N
Angina	Y / N	Frequent Headaches	Y / N	Lung Disease	Y / N
Arthritis/Gout	Y / N	Glaucoma	Y / N	Mitral Valve Prolapse	Y / N
Artificial Heart Valve	Y / N	Heart Attack/Failure	Y / N	Pain in Jaw Joint	Y / N
Artificial Joint, Date?_____	Y / N	Heart Murmur	Y / N	Radiation Treatment	Y / N
Asthma	Y / N	Heart Pacemaker	Y / N	Renal Dialysis	Y / N
Blood Disease	Y / N	Heart Trouble/Disease	Y / N	Sinus Trouble	Y / N
Bruise Easily	Y / N	Hemophilia	Y / N	Stomach/Intestinal Disease	Y / N
Cancer	Y / N	Hepatitis A, B or C	Y / N	Stroke	Y / N
Chemotherapy	Y / N	Herpes	Y / N	Thyroid Disease	Y / N
Chest Pains	Y / N	High Blood Pressure	Y / N	Tumors or Growths	Y / N
Cold Sore/Fever Blisters	Y / N	Hives or Rash	Y / N	Ulcers	Y / N
Congenital Heart Disorder	Y / N	Hypoglycemia	Y / N	Acid Reflux or GERD	Y / N
Diabetes	Y / N	Irregular Heartbeat	Y / N		

Have you ever had any serious illness not listed above? Y / N_____

Comments:

_____

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_____DATE_____