

Though dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever had any of the following? Please check those that apply:

<input type="checkbox"/> AIDS / HIV positive	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Fainting spells/dizziness	<input type="checkbox"/> Nervous Disorder
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Frequent cough	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Angina	<input type="checkbox"/> Headaches	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Arthritis/ Gout	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Heart Attack/Heart Failure	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Hives/Rash	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Tumors/Growths
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Other

1) Please list all medications you are taking: _____

2) Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other: _____

3) Do you have any medical conditions for which you must take antibiotics prior to dental appointments?
 No Yes: _____

4) Have you ever had any complications following dental treatment? No Yes
 If yes, please explain: _____

5) Have you ever been admitted to the hospital, had a major operation, or needed emergency care during the past two years? If yes, please explain: _____

6) Are you now under the care of a physician? No Yes
 If yes, please explain: _____
 Name of Physician: _____ Phone #: _____

7) Do you use tobacco? No Yes

8) Do you use controlled substances? No Yes

9) Do you have any health problems that need further clarification? No Yes
 If yes, please explain: _____

*Women: Are you: Pregnant/Trying to get pregnant? Nursing? Taking Oral Contraceptives?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

 Signature of patient, parent or guardian

 Date: