

Name _____

Are you under a physician’s care now? Why? Who? _____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or neck? Discuss _____ Yes No

Are you taking any medications, pills or drugs? What? _____ Yes No

Are you on a special diet? Discuss _____ Yes No

Are you allergic to any medications or substances? Please check box below Yes No

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

• If yes to any of the starred conditions, please call prior to your appointment ... Premedication may be required

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble/Disease | <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur* |
| <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Angina/Chest Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Renal Dialysis | <input type="checkbox"/> | <input type="checkbox"/> | X-Ray Treatments (Radiation) | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack/Failure | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia (Bleeding Problem) |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Intestinal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse* |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/Gout | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of Limbs |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever* | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve* |
| <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Medicine | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint* |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing Problem | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Pace Maker* | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery* |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Cough | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer’s Disease | <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Allergies (Medicines) |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A (Infectious) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B (Serum) | <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Hives or Rash |

WOMEN (Please check):

Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss _____ Yes No

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)