



Patient First Name _____

Patient Last Name _____

Patient Account No. _____

Medical Alert _____

Physician's Name: _____

Phone: _____

1. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes No

If Yes, please list name and dosage _____

2. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? Yes No

If Yes, please list name and dosage _____

3. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No

If Yes, please specify _____

4. Have you been a patient in the hospital during the past Yes No

5. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item:

- | | | | | | |
|------------------------------------|--|-------------------------|--|--------------------------------|--|
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A B C | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | A.I.D.S. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve/Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever/Allergy/Hives | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease/Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex Sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swollen Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diet (Special/Restricted) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous/Anxious | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints (hip, knee, etc) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Psychological Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

6. Have you lost or gained more than 10 pounds in the past year? Yes No

7. Do you have or have you had any disease, condition, or problem not listed? Yes No

If Yes, please list: _____

8. Are you pregnant or think you could be pregnant? Yes No Months: _____

9. Nursing? Yes No **10. Do you use birth control prescriptions?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: _____ **Date:** _____

Dentist Signature: _____ **History Review:** _____