

Are you allergic to the following?

О Aspirin О Penicillin О Codeine О Acrylic О Metal О Latex О Sulfa Drug О Local Anesthetics

OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Women: Are you? О Nursing? О Pregnant/Trying to get pregnant? О Taking oral contraceptives?

**Date:\_\_\_**

**Patient Name:**

Are you under a physician’s care now? О Yes О No If yes

Have you ever been hospitalized or О Yes О No If yes

had a major operation?

Have you ever had a serious head О Yes О No If yes

or neck injury?

Have you ever taken Fosamax, Boniva, О Yes О No If yes

Actonel or any other medications

containing Bisphosphonates?

Are you taking any medications, О Yes О No If yes

pills or drugs?

containing Bisphosphonates?

Are you on a special diet? О Yes О No

Do you use Tobacco О Yes О No

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FOR OFFICE USE ONLY

Dentist X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, all of the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

**Diabetes О Yes О No**

**Drug Addiction О Yes О No**

**Easily Winded О Yes О No**

**Emphysema О Yes О No**

**Epilepsy/Seizures О Yes О No**

**Excessive bleeding О Yes О No**

**Excessive Thirst О Yes О No**

**Frequent Cough О Yes О No**

**Freq. Headaches О Yes О No**

**Glaucoma О Yes О No**

**Heart Attack Failure О Yes О No**

**Heart Murmur О Yes О No**

**Heart Pacemaker О Yes О No**

**Heart Trouble О Yes О No**

**Hemophillia О Yes О No**

**Hepatitis A О Yes О No**

**Hep B or C О Yes О No**

**Herpes О Yes О No**

**High blood Pressure О Yes О No**

Do you use controlled substances? О Yes О No If yes

**Aids/HIV Positive О Yes О No**

**Alzheimer’s Disease О Yes О No**

**Anaphylaxis О Yes О No**

**Anemia О Yes О No**

**Angina О Yes О No**

**Arthritis/Gout О Yes О No**

**Artificial Heart Valve О Yes О No**

**Artificial Joint О Yes О No**

**Asthma О Yes О No**

**Blood Disease О Yes О No**

**Blood Transfusion О Yes О No**

**Breathing Problems О Yes О No**

**Bruise Easily О Yes О No**

**Cancer О Yes О No**

**Chemotherapy О Yes О No**

**Chest Pains О Yes О No**

**Cold Sores О Yes О No**

**Convulsions О Yes О No**

**Cortisone Medicine О Yes О No**

**High Cholesterol О Yes О No**

**Hives or rash О Yes О No**

**Hypoglycemia О Yes О No**

**Leukemia О Yes О No**

**Liver Disease О Yes О No**

**Low Blood Pressure О Yes О No**

**Lung Disease О Yes О No**

**Mitral Valve Prolapse О Yes О No**

**Osteoporosis О Yes О No**

**Pain in Jaw Joints О Yes О No**

**Psychiatric Care О Yes О No**

**Radiation О Yes О No**

**Shingles О Yes О No**

**Sinus Trouble О Yes О No**

**Stomach Disease О Yes О No**

**Stroke О Yes О No**

**Thyroid Disease О Yes О No**

**Tuberculosis О Yes О No**

**Tumors О Yes О No**