Patient Name:_____

Date:_____

Person & Darlington
Family and Cosmetic Dentistry

Although 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, can affect your mouth and how we do treatment.

Are you under a physician's care now?	▫ Yes	▫ No	If yes _____
Have you ever been hospitalized or had a major operation?	▫ Yes	▫ No	If yes _____
Have you ever had a serious head or neck injury?	▫ Yes	▫ No	If yes _____
Are you taking medications, pills, or drugs?	▫ Yes	▫ No	If yes _____
Do you take, or have you taken, Phen-Fen or Redux?	▫ Yes	▫ No	If yes _____
Have you ever taken Fosamax, Bonita, Actonel or any other medications containing bisphosphonates?	▫ Yes	▫ No	If yes _____
Are you on a special diet?	▫ Yes	▫ No	
Do you use tobacco?	▫ Yes	▫ No	
Do you use controlled substances?	▫ Yes	▫ No	If yes _____

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

Are you allergic to any of the following:

▫Aspirin ▫Penicillin ▫Codeine ▫Acrylic
▫Metal ▫Latex ▫Sulfa Drugs ▫Local Anesthetics
Other_____

AIDS/HIV+	▫ Yes ▫ No	Cortisone Medicine	▫ Yes ▫ No	Hemophilia	▫ Yes ▫ No	Radiation Treatment	▫ Yes ▫ No
Alzheimer's Disease	▫ Yes ▫ No	Diabetes	▫ Yes ▫ No	Hepatitis A	▫ Yes ▫ No	Recent Weight Loss	▫ Yes ▫ No
Anaphylaxis	▫ Yes ▫ No	Drug Addiction	▫ Yes ▫ No	Hepatitis B or C	▫ Yes ▫ No	Renal Dialysis	▫ Yes ▫ No
Anemia	▫ Yes ▫ No	Easily Winded	▫ Yes ▫ No	Herpes (Oral)	▫ Yes ▫ No	Rheumatic Fever	▫ Yes ▫ No
Angina	▫ Yes ▫ No	Emphysema	▫ Yes ▫ No	High Blood Pressure	▫ Yes ▫ No	Rheumatism	▫ Yes ▫ No
Arthritis/Gout	▫ Yes ▫ No	Epilepsy or Seizures	▫ Yes ▫ No	High Cholesterol	▫ Yes ▫ No	Scarlet Fever	▫ Yes ▫ No
Artificial Heart Valve	▫ Yes ▫ No	Excessive Bleeding	▫ Yes ▫ No	Hives or Rash	▫ Yes ▫ No	Shingles	▫ Yes ▫ No
Artificial Joint	▫ Yes ▫ No	Excessive Thirst	▫ Yes ▫ No	Hypoglycemia	▫ Yes ▫ No	Sickle Cell Disease	▫ Yes ▫ No
Asthma	▫ Yes ▫ No	Fainting Spells/Dizziness	▫ Yes ▫ No	Irregular Heartbeat	▫ Yes ▫ No	Sinus Trouble	▫ Yes ▫ No
Blood Disease	▫ Yes ▫ No	Frequent Diarrhea	▫ Yes ▫ No	Kidney Problems	▫ Yes ▫ No	Spina Bifida	▫ Yes ▫ No
Blood Transfusion	▫ Yes ▫ No	Frequent Cough	▫ Yes ▫ No	Leukemia	▫ Yes ▫ No	Stomach/Intestinal Disease	▫ Yes ▫ No
Breathing Problems	▫ Yes ▫ No	Frequent Headaches	▫ Yes ▫ No	Liver Disease	▫ Yes ▫ No	Stroke	▫ Yes ▫ No
Bruise Easily	▫ Yes ▫ No	Genital Herpes	▫ Yes ▫ No	Low Blood Pressure	▫ Yes ▫ No	Swelling of Limbs	▫ Yes ▫ No
Cancer	▫ Yes ▫ No	Glaucoma	▫ Yes ▫ No	Lung Disease	▫ Yes ▫ No	Thyroid Disease	▫ Yes ▫ No
Chemotherapy	▫ Yes ▫ No	Hay Fever	▫ Yes ▫ No	Mitral Valve Prolapse	▫ Yes ▫ No	Tonsillitis	▫ Yes ▫ No
Chest Pains	▫ Yes ▫ No	Heart Attack/Failure	▫ Yes ▫ No	Osteoporosis	▫ Yes ▫ No	Tuberculosis	▫ Yes ▫ No
Cold Sores/Fever Blisters	▫ Yes ▫ No	Heart Murmur	▫ Yes ▫ No	Pain in Jaw Joints	▫ Yes ▫ No	Tumors or Growths	▫ Yes ▫ No
Congenital Heart Disorder	▫ Yes ▫ No	Heart Pacemaker	▫ Yes ▫ No	Parathyroid Disease	▫ Yes ▫ No	Ulcers	▫ Yes ▫ No
Convulsions	▫ Yes ▫ No	Heart Trouble/Disease	▫ Yes ▫ No	Psychiatric Care	▫ Yes ▫ No	Venereal Disease	▫ Yes ▫ No
						Yellowing/Jaundice	▫ Yes ▫ No

Have you ever had any serious illness not listed above? □Yes □No If Yes_____

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:

X_____ **Date**_____