

Patient Name: _____

Birth Date: _____

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 you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please Circle

- Are you under a physician's care now? Yes No If yes, please list physician's name and phone number: _____
- Have you recently been hospitalized or had any major operations? Yes No If yes, please explain: _____
- Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes No If yes, please explain: _____
- Do you use tobacco? Yes No If yes, please list type, how long, and how frequent: _____

Are you ALLERGIC to any of the following? (Please circle any that apply)

Aspirin	Penicillin	Codeine	Local Anesthetics	Latex	Sulfa Drugs
Other If yes, please explain: _____					

Do you have, or have you had, any of the following?

Yes	No	AIDS/HIV Positive	Yes	No	Drug Addiction	Yes	No	Irregular Heartbeat
Yes	No	Anemia	Yes	No	Emphysema	Yes	No	Kidney Problems
Yes	No	Artificial Heart Valve	Yes	No	Epilepsy or Seizures	Yes	No	Liver Disease
Yes	No	Artificial Joint	Yes	No	Excessive Bleeding	Yes	No	Lung Disease
Yes	No	Asthma	Yes	No	Heart Attack/Failure	Yes	No	Mitral Valve Prolapse
Yes	No	Blood Disease	Yes	No	Heart Murmur	Yes	No	Psychiatric Care
Yes	No	Breathing Problem	Yes	No	Heart Pacemaker	Yes	No	Renal Dialysis
Yes	No	Cancer	Yes	No	Heart Disease	Yes	No	Sickle Cell Disease
Yes	No	Chest Pains	Yes	No	Hemophilia	Yes	No	Stomach/Intestinal Disease
Yes	No	Congenital Heart Disorder	Yes	No	Hepatitis (A, B, or C)	Yes	No	Stroke
Yes	No	Diabetes	Yes	No	High Blood Pressure	Yes	No	Thyroid Disease

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

If yes, please explain: _____

Please list all medications that you are currently taking below:

Women:	Are you		
	Pregnant/Trying to get Pregnant?	Yes	No
	Nursing?	Yes	No

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 Ford Family Dental of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____