

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex
 Local Anaesthetic Other (if yes please explain)_____

Have you ever had any of the following? Please check if applies:

- | | | |
|---|---|---|
| Y N | Y N | Y N |
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Artificial Heart valve | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur MVP | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart PACE MAKER | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Parathyroid disease | <input type="checkbox"/> OTHER:_____ |
| <input type="checkbox"/> Fainting or Dizziness | | |

Have you ever had a serious head or neck injury? () YES () NO If yes please explain_____

Have you ever been told you need to pre-medicate with antibiotics prior to dental work? () NO

() YES _____

Do you or have you taken Fosamax? () YES () NO _____

Are you on a special diet? () YES () NO _____

Do you use, or have you used, tobacco? () YES () NO _____

Do you use controlled substances? () YES () NO _____

Please List ANY MEDICATIONS you are taking:_____

WOMEN: Are you: Pregnant? Due date_____ Taking Oral Contraceptives? Nursing?

In Case of **EMERGENCY** give **NAME** and **PHONE NUMBER** of someone **NOT LIVING WITH YOU**.

Are you now under the care of a physician or have you ever had a serious illness not listed above?

() YES () NO If yes please explain_____

Name of Physician: _____ Phone:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature of Patient (or parent or guardian) _____

Relationship to Patient:_____ Date:_____