

Medical History

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 medications that you may be taking could have an important interrelationship with the density you will receive. Thank you for answering the following questions;

Are you under a physician's care now? Yes No If yes, please explain _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain _____

Are you taking any medications, pills or drugs? Yes No If yes, please explain _____

Do you take or have you taken Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you snore? Yes No

Have you been diagnosed with sleep apnea? Yes No

Women, Are you
Taking oral contraceptives?
Pregnant/Trying to get pregnant? Nursing?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other _____

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

- | | | | | |
|-------------------------------|----------------------------------|------------------------------|------------------------------|-----------------------------------|
| AIDS/HIV Positive | Chest Pains | Frequent Headaches | Irregular Heartbeat | Scarlet Fever |
| Alzheimer's disease | Cold Sores/Fever Blisters | Genital Herpes | Kidney Problems | Shingles |
| Anaphylaxis | Congenital Heart Disorder | Glaucoma | Leukemia | Sickle Cell Disease |
| Anemia | Convulsions | Hay Fever | Liver Disease | Sinus Trouble |
| Angina | Cortisone Medicine | Heart Attack/Failure | Low Blood Pressure | Spina Bifida |
| Arthritis/Gout | Diabetes | Heart Murmur | Lung Disease | Stomach/Intestinal Disease |
| Artificial Heart Valve | Drug Addiction | Heart Pace Maker | Mitral Valve Prolapse | Stroke |
| Artificial Joint | Easily Winded | Heart Trouble/Disease | Pain in Jaw Joints | Swelling of Limbs |
| Asthma | Emphysema | Hemophilia | Parathyroid Disease | Thyroid Disease |
| Blood Disease | Epilepsy or Seizures | Hepatitis A | Psychiatric Care | Tonsillitis |
| Blood Transfusion | Excessive Bleeding | Hepatitis B or C | Radiation Treatments | Tuberculosis |
| Breathing Problem | Excessive Thirst | Herpes | Recent Weight Loss | Tumors or Growths |
| Bruise Easily | Fainting Spells/Dizziness | High Blood Pressure | Renal Dialysis | Ulcers |
| Cancer | Frequent Cough | Hives or Rash | Rheumatic Fever | Venereal Disease |
| Chemotherapy | Frequent Diarrhea | Hypoglycemia | Rheumatism | Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain _____

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 _____ DATE _____