Eastern Slope Dental

Patient Name: _____ Birth Date: _____

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

Women: Are you…

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ No Known Allergies

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other If yes _____

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

AIDS/HIV Positive	O Yes O No	Congenital Heart Disorder	O Yes O No	Hemophilia	O Yes O No	Parathyroid Disease	O Yes O No
Alzheimer's Disease	O Yes O No	Cortisone Medicine	O Yes O No	Hepatitis A	O Yes O No	Psychiatric Care	O Yes O No
Anemia	O Yes O No	Diabetes	O Yes O No	Hepatitis B or C	O Yes O No	Radiation Treatments	O Yes O No
Angina	O Yes O No	Drug Addiction	O Yes O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Arthritis/Gout	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O No
Artificial Heart Valve	O Yes O No	Epilepsy or Seizures	O Yes O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Artificial Joint	O Yes O No	Excessive Bleeding	O Yes O No	Kidney Disease	O Yes O No	Sickle Cell Disease	O Yes O No
Asthma	O Yes O No	Excessive Thirst	O Yes O No	Kidney Problems	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	O Yes O No	Frequent Headache	O Yes O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Blood Transfusion	O Yes O No	Glaucoma	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Hay Fever	O Yes O No	Low Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Cancer	O Yes O No	Heart Attack/Failure	O Yes O No	Lung Disease	O Yes O No	Tuberculosis	O Yes O No
Chemotherapy	O Yes O No	Heart Murmur	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tumors or Growths	O Yes O No
Chest Pains	O Yes O No	Heart Pacemaker	O Yes O No	Osteoporosis	O Yes O No	Ulcers	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Trouble/Disease	O Yes O No	Pain in Jaw Joints	O Yes O No	Venereal Disease	O Yes O No

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

Comments:

Are you required by a doctor to pre-medicate for any dental procedures? Yes No

Y → Which pre-medication do you take? _____ Why? _____

When was surgery? _____ Treating Doctor? _____

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

X Date: _____