

Health Information

Are you allergic to any of the following? (check boxes that apply)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> Other |

Please list additional drugs that cause allergic reactions? _____

Are you taking any of the following? (check boxes that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Cold Remedies | <input type="checkbox"/> Recreational Drugs |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Digitalis/Heart Medication | <input type="checkbox"/> Steroids/Cortisone |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Insulin/Diabetes Drugs | <input type="checkbox"/> Thyroid Medicine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nitroglycerin | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Amino Biphosphonate | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blood Pressure Medication | (Fosamax/Boniva) | |

Are you taking any prescription and/or over-the-counter drugs not listed above? _____

1. Have you ever had any of the following? (check boxes that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> A.I.D.S. / HIV |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> TB | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia (Prolonged Bleeding) | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Jaw or Ear Pain (TMJ) | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Special Diet past or present (like Fen-Phen) | <input type="checkbox"/> Acid Reflux |
| | | <input type="checkbox"/> Other |

2. Name of family physician _____ Phone _____

3. Date of last physical? _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 4. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any major operations? If so, what | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a serious accident involving head/mouth injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you smoke or use tobacco in any form? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you on a diet at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you in general good health at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have previous cuts healed slowly or presented other complications? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you pregnant? Due Date | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have a history of fainting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Is there any other information that should be known about your health or previous dental visits? . | <input type="checkbox"/> | <input type="checkbox"/> |

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for the benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Today's Date _____ Signature _____