SRD | SOUTH RIDGE DENTAL

Patient name: _____ **DOB**_____

Although dental personnel primarily treat the area around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

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

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

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

_____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, when? _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes, when? _____

Do you have an artificial joint? Yes No If yes, where? _____

Do you use tobacco? Yes No If yes, what? _____

Do you use controlled substances? Yes No If yes, what? _____

Women: Are you

Pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa drugs	Other _____

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Unexplained weight loss	Yes No
Anaphylaxis	Yes No	Drug addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Oral herpes	Yes No	Rheumatic Fever	Yes No	Angina	Yes No
Emphysema	Yes No	High blood pressure	Yes No	Rheumatism	Yes No	Arthritis/Gout	Yes No
Epilepsy or seizures	Yes No	High cholesterol	Yes No	Scarlet fever	Yes No	Artificial heart valve	Yes No
Excessive bleeding	Yes No	Hives or rash	Yes No	Shingles	Yes No	Excessive thirst	Yes No
Hypoglycemia	Yes No	Sickle Cell disease	Yes No	Asthma	Yes No	Fainting/dizzy spells	Yes No
Irregular heartbeat	Yes No	Sinus trouble	Yes No	Blood disease	Yes No	Frequent cough	Yes No
Kidney problems	Yes No	Spina Bifida	Yes No	Blood transfusion	Yes No	Frequent diarrhea	Yes No
Leukemia	Yes No	Stomach disease	Yes No	Breathing issues	Yes No	Frequent headaches	Yes No
Liver disease	Yes No	Stroke	Yes No	Bruise easily	Yes No	Low blood pressure	Yes No
Swelling of limbs	Yes No	Cancer	Yes No	Glaucoma	Yes No	Lung disease	Yes No
Thyroid disease	Yes No	Chemotherapy	Yes No	Hay Fever	Yes No	Mitral valve prolapse	Yes No
Tonsillitis	Yes No	Chest pains	Yes No	Heart attack/failure	Yes No	Osteoporosis	Yes No
Tuberculosis	Yes No	Cold sores	Yes No	Heart murmur	Yes No	Pain in jaw joints	Yes No
Tumors or growths	Yes No	Congenital heart		Heart pacemaker	Yes No	Parathyroid disease	Yes No
Ulcers	Yes No	disorder	Yes No	Heart disease	Yes No	Psychiatric care	Yes No
Venereal disease	Yes No	Convulsions	Yes No				

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

Signature of patient, parent, or guardian _____

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.