Doman Dental Care

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Previous Dentist: *

Date of Last Dental Visit * _____

Reason for this visit: *

Have you ever been hospitalized or had a major operation? * ◯ Yes ◯ No

If yes, please explain:

Are you taking any medications, pills, or drugs? *

Do you take, or have you taken, Phen-Fen or Redux? * ◯ Yes ◯ No

Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? * ◯ Yes ◯ No

Are you on a special diet? * ◯ Yes ◯ No

Do you use tobacco? * ◯ Yes ◯ No

Do you use controlled substances? * ◯ Yes ◯ No

Women- are you pregnant/trying to get pregnant? ◯ Yes ◯ No

Women- are you nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Local Anesthetics
◯ Other

Have you ever had any of the following? Please check those that apply: *

☐ ADIS/HIV Positive	☐ Alzheimer's Disease	☐ Anaphylaxis	☐ Anemia	☐ Angina
☐ Arthritis/Gout	☐ Artificial Heart Valve	☐ Artificial Joint	☐ Asthma	☐ Blood Diseases
☐ Blood Transfusion	☐ Breathing Problems	☐ Bruise Easily	☐ Cancer	☐ Chemotherapy
☐ Chest Pains	☐ Cold Sores/Fever Blisters	☐ Congenital Heart Disorder	☐ Convulsions	☐ Cortisone Medicine
☐ Diabetes	☐ Drug Addiction	☐ Easily Winded	☐ Emphysema	☐ Epilepsy or Seizures
☐ Excessive Bleeding	☐ Excessive Thirst	☐ Fainting spells/Dizziness	☐ Frequent Cough	☐ Frequent Headaches
☐ Hay Fever	☐ Heart Attach/Failure	☐ Heart Murmur	☐ Heart Pace Maker	☐ Heart Trouble/Disease
☐ Hemophilia	☐ Hepatitis A	☐ Hepatitis B or C	☐ High Blood Pressure	☐ High Cholesterol
☐ Hives or Rash	☐ Hypoglycemia	☐ Irregular Heartbeat	☐ Kidney Problems	☐ Leukemia
☐ Liver Disease	☐ Low Blood Pressure	☐ Lung Disease	☐ Mitral Valve Prolapse	☐ Osteoporosis
☐ Pain in Jaw Joints	☐ Parathyroid Disease	☐ Psychiatric Case	☐ Radiation Treatments	☐ Recent Weight Loss
☐ Renal Dialysis	☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever	☐ Shingles
☐ Sickel Cell Disease	☐ Sinus Trouble	☐ Spina Bifida	☐ Stomach/Intestinal Disease	☐ Stroke
☐ Swelling of Limbs	☐ Thyroid Disease	☐ Tonsillitis	☐ Tuberculosis	☐ Tumors or Growths
☐ Ulcers	☐ None			

Have you ever had a serious illness not listed above? * ◯ Yes ◯ No

If yes, please explain:

_____

_____

_____

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 doctor at the next appointment without fail.

Signature _____ **Date** _____

Signature of patient, parent or guardian

Response Date: _____