Forest City Family Dentistry

Patient Name: Birth Date: Date Created:

Are you, or have you been seen in the past year by a primary care physician. If yes, please list name and location	◯ Yes ◯ No	If yes	
Are you seen by any medical specialists? If yes, please list name(s) and location(s)	◯ Yes ◯ No	If yes	
Have you had any serious illness, injury, or been hospitalized? If yes, for what and how long ago?	◯ Yes ◯ No	If yes	
Have you had heart surgery? If yes, please specify what type and date.	◯ Yes ◯ No	If yes	
Have you had a total joint replacement? If yes, please specify the joint and date of surgery.	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Do you or have you used tobacco products? If yes, please specify type, quanity, and for how long?	◯ Yes ◯ No	If yes	
How interested are you in stopping? VERY SOMEWHAT NOT INTERESTED	◯ Yes ◯ No	If yes	
Do you use or have you used prescription drugs or street drugs for recreational purposes?	◯ Yes ◯ No	If yes	
WOMEN: Are you pregnant or believe you could be pregnant? Nursing?	◯ Yes ◯ No	If yes	

Are you allergic to any of the following?

☐ Penicillin	☐ Codeine	☐ Latex	☐ Local Anesthetics
☐ Clindamycin	☐ Metal	☐ Sulfa	☐ Aspirin

Other drug allergies? ☐ If yes

Do you now, or have a HISTORY of the following?

☐ Difficulty hearing	☐ Artificial Heart Valve	☐ High blood pressure
☐ Visual Impairment	☐ Congenital Heart Disease	☐ High Cholesterol
☐ Memory Issues	☐ Artifical Joint	☐ Blood Diseae
☐ Alzheimer's disease	☐ Previous Endocarditis	☐ Breathing Problems
☐ Learning disability	☐ Pacemaker	☐ COPD
☐ Spectrum of Autism	☐ Heart Attack	☐ Neurologic/Nerve Problem
☐ Drug Addiction	☐ Heart Problems	☐ Mental Health Disorder
☐ Stroke	☐ Kidney dialysis	☐ Kidney disease
☐ Asthma	☐ Renal Failure	☐ Stomach/Intestinal Disease
☐ Chest Pains	☐ Diabetes	☐ Immune System Problems
☐ Fainting	☐ Liver Failure	☐ Liver Problem
☐ Dizziness	☐ Cancer	☐ Bone/Muscle Disease
☐ Epilepsy/ Seizures	☐ Chemotherapy	☐ Eating Disorder
☐ Hepatitis	☐ Radiation	☐ Eye/Ear/Nose/ Throat Problems
☐ HIV/AIDS	☐ Migraines/ Frequent Headaches	☐ Snoring
☐ Jaw Pain	☐ Dry Mouth	☐ Sleep Apnea

Please list any additional medical issues here or explanation of above (if needed):

Please list ALL medications (prescription, over the counter, and herbals):

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:

X_____ Date:_____