Patient Name: _____ D.O.B. _____

Emerald West DENTAL
CHAD D. HESS D.D.S. • RANDY MOSS D.D.S.

Although dental personnel primarily treat the area in and 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.

	Y	N	
Are you under a physician's care now?			If yes: _____
Have you ever been hospitalized or had a major operation?			If yes: _____
Have you ever had a serious head or neck injury?			If yes: _____
Are you taking any medications, pills, or drugs?			If yes: _____
Do you take, or have you taken, Phen-Fen or Redux?			If yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			If yes: _____
Are you on a special diet?			If yes: _____
Do you use tobacco?			If yes: _____

Women: Are you…

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

Are you allergic to any of the following?

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

	Y	N	
Do you use controlled substances?			If yes: _____

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

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive			Cortisone Medicine			Hemophilia			Radiation Treatments		
Alzheimer's Disease			Diabetes			Hepatitis A			Recent Weight Loss		
Anaphylaxis			Drug Addiction			Hepatitis B or C			Renal Dialysis		
Anemia			Easily Winded			Herpes			Rheumatic Fever		
Angina			Emphysema			High Blood Pressure			Rheumatism		
Arthritis/Gout			Epilepsy or Seizures			High Cholesterol			Scarlet Fever		
Artificial Heart Valve			Excessive Bleeding			Hives or Rash			Shingles		
Artificial Joint			Excessive Thirst			Hypoglycemia			Sickle Cell Disease		
Asthma			Fainting Spells/Dizziness			Irregular Heartbeat			Sinus Trouble		
Blood Disease			Frequent Cough			Kidney Problems			Spina Bifida		
Blood Transfusion			Frequent Diarrhea			Leukemia			Stomach/Intestinal Disease		
Breathing Problems			Frequent Headaches			Liver Disease			Stroke		
Bruise Easily			Genital Herpes			Low Blood Pressure			Swelling of Limbs		
Cancer			Glaucoma			Lung Disease			Thyroid Disease		
Chemotherapy			Hay Fever			Mitral Valve Prolapse			Tonsillitis		
Chest Pains			Heart Attack/Failure			Osteoporosis			Tuberculosis		
Cold Sores/Fever Blisters			Heart Murmur			Pain in Jaw Joints			Tumors or Growths		
Congenital Heart Disorder			Heart Pacemaker			Parathyroid Disease			Ulcers		
Convulsions			Heart Trouble/Disease			Psychiatric Care			Venereal Disease		

	Y	N
Have you ever had any serious illness not listed above?		

Comments:

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: _____