Keystone Dental Care 2017(Copy)

Patient Name: Birth Date: Date Created:

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.

Are you in good health?	◯ Yes ◯ No	
Has there been any changes in your general health within the past year?	◯ Yes ◯ No	If yes
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamx, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Do you use smokeless tobacco or smoke?	◯ Yes ◯ No	If yes
Do you take a blood thinner (Anticoagulants)?	◯ Yes ◯ No	If yes
Do you take Aspirin?	◯ Yes ◯ No	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	☐ Antibiotics
☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics	☐ Barbitutates

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

AIDS/HIV Positive ◯ Yes ◯ No	Hepatitis B ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No
Recent Weight Loss ◯ Yes ◯ No	Hepatitis C ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No
Rheumatic Heart Disease ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Arthritis/Painful Joints ◯ Yes ◯ No
Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Asthma ◯ Yes ◯ No
Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No
Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Slow Healing Cuts ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No
Frequent Diarrhea ◯ Yes ◯ No	Stomach Ulcer/Hyperacidity ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No
Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No	STD ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No
Swelling of Limbs ◯ Yes ◯ No	Cancer ◯ Yes ◯ No	Thyroid Problems ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No
Mitral Valve Prolapse ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Tuberculosis ◯ Yes ◯ No	Coronary Insufficiency ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Conronary Occlusion ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Mental Health Problems ◯ Yes ◯ No	Obese ◯ Yes ◯ No
Swollen Glands in Neck ◯ Yes ◯ No	Physically Inactive ◯ Yes ◯ No	Shortness of Breath ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No
COPD ◯ Yes ◯ No	Allergies ◯ Yes ◯ No	Arteiosclerosis ◯ Yes ◯ No	Cardiovascular Disease ◯ Yes ◯ No
Damaged Heart Valves ◯ Yes ◯ No	Inborn Heart Defect ◯ Yes ◯ No		

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes
Have you used any non-prescription drugs prior to this appointment?	◯ Yes ◯ No	If yes

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:_____

Signature of Dentist:

X Date:_____