MONADNOCK DENTAL ASSOCIATES, PLLC

Patient Name: Birth Date: Date Created:

PLEASE FILL OUT THIS FORM AND HAND IT TO YOUR DENTAL CARE PROVIDER WHEN YOU ARE SEATED.

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. If more room for information is needed, please use reverse side of this form.

Primary Care

Name of Primary Care Physician? ______ omment ______

Question		
Are you being treated for any current medical condition?	Yes No	If yes
Have you been hospitalized or had a major operation within the last two years?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs, prescription or non-prescription?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you smoke/chew tobacco? Please specify.	Yes No	If yes
Do you consume alcohol socially, occasionally, daily, recovering?	Yes No	If yes
Do you use recreational drugs or substances? Please specify.	Yes No	If yes
Do you need to pre-medicate with an antibiotic for dental appointments?	Yes No	If yes

Location

Do you have trouble climbing stairs? Yes No

Are you allergic to any of the following?

- Aspirin
- Latex
- Tree Nut
- Codeine
- Sulfa Drugs
- Other
- Acrylic
- Local Anesthetics
- Metal
- Antibiotics

Women: Are you...

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

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease/Dementia	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Anaphylaxis	Yes No
Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No	Anemia	Yes No
Easily Winded	Yes No	Angina/Chest Pains	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Artificial Heart Valve	Yes No
Excessive Bleeding	Yes No	Hives or Rash	Yes No	Artificial Joint	Yes No	Excessive Thirst	Yes No
Sickle Cell Disease	Yes No	Asthma	Yes No	Fainting Spells/Dizzines	Yes No	Irregular Heartbeat	Yes No
Sinus Trouble	Yes No	Kidney Problems	Yes No	Blood Transfusion	Yes No	Leukemia	Yes No
Stomach/Intestinal Disease/Acid Reflux	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Low Blood Pressure	Yes No	Cancer	Yes No	Glaucoma	Yes No
Thyroid Disease	Yes No	Chemotherapy	Yes No	Seasonal Allergies	Yes No	Mitral Valve Prolapse	Yes No
Recurrent Tonsillitis	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blister	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Heart Pacemaker	Yes No	Heart Trouble/Diseas	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Respiratory Conditions	Yes No	Jaundice	Yes No	Anxiety/Depression	Yes No	ADD/ADHD	Yes No

Have you ever had any serious illness not listed 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:__________