Saxon Dental

Patient Name:_____ Birth Date:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 under a physician's care now? □ Yes □No If so, please list your Dr Name:_____ Phone:_____

Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain_____

Do you use tobacco ? □ Yes □ No Do you use controlled substance? □Yes □No

Women: Are you…
Pregnant/trying to get pregnant □ Yes □ No Expect due date:_____
Taking oral contraceptives? □ Yes □ No Nursing □Yes □No

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Latex □Sulfa Drugs □ Metal

□Other_____

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

AIDS/HIV…….. □Yes □No	Heart attack/Failure….. □Yes □No	Thyroid Disease…… □Yes □No
Anemia …….. □Yes □No	Heart Murmur…….. □Yes □No	Tuberculosis…….. □Yes □No
Arthritis……. □Yes □No	Heart Pacemaker…….. □Yes □No	
Artificial Heart valve……. □Yes □No	Hepatitis A…….. □Yes □No	
Artificial Joint…… □Yes □No	Hepatitis B or C…….. □Yes □No	
Asthma…….. □Yes □No	High Blood Pressure …□Yes □No	
Bruise Easily……. □Yes □No	High Cholestrerol…….□Yes □No	
Cancer…… □Yes □No	Irregular Heartbeat……□Yes □No	
Chest Pain……. □Yes □No	Liver Disease……□Yes □No	
Cold Sores/ Fever Blisters..□Yes □No	Low Blood Pressure…..□Yes □No	
Congenital Heart Disorder.. □Yes □No	Mitral Heart Prolapse...□Yes □No	
Convulsion……. □Yes □No	Pacemaker……..□Yes □No	
Diabetes……. □Yes □No	Pins/Rods……..□Yes □No	
Epilepsy or Seizures…….. □Yes □No	Psychiatric Care……□Yes □No	
Fainting/ Dizziness…… □Yes □No	Rheumatic Fever…….. □Yes □No	
Glaucoma…… □Yes □No	Sinus Trouble…… □Yes □No	
Hay fever…….. □Yes □No	Stroke…….. □Yes □No	

Do you take any of the following medications?

Anticoagulants (e.g Coumadin, Plavix)	□Yes □No	Other:_____
High blood pressure medicine	□Yes □No	_____
Insulin or similar drug	□Yes □No	_____
Aspirin Daily	□Yes □No	_____
Nitroglycerine	□Yes □No	_____
Fosamax	□Yes □No	_____

REMARK FOR DOCTOR USE ONLY

REVIEWED MEDICAL HISTORY
Doctor Initial Date

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge and understand providing incorrect information can be dangerous to my (or patient's) health. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. It is my responsibility to inform the dental office of any changed in my medical status or medication.

_____ _____
Signature of Patient or Guardian Date