

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 receive. Please circle the appropriate answers. Answer and follow questions carefully and thoroughly:

Are you under a physician's care at this time? Yes No If yes, please explain _____
 Have you ever been hospitalized or had a major operation? Yes No If yes, please explain _____
 Have you ever had a serious head or neck injury? Yes No If yes, please explain _____
 Are you currently taking any medications, pills, or drugs? Yes No If yes, please explain _____
 Are you on a special diet? Yes No If yes, please explain _____
 Do you use tobacco? Yes No If yes, please explain _____
 Do you use controlled substances? Yes No If yes, please explain _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If other, please explain: _____

WOMEN:

Pregnant/Trying to become pregnant? Yes No Taking Oral Contraceptives? Yes No Nursing? Yes No

CIRCLE IF YOU NOW HAVE, OR HAVE EVER HAD, ANY OF THE FOLLOWING:

- | | | | |
|---------------------------|----------------------|-----------------------------|------------------------------|
| AIDS or HIV Positive | Cortisone Medicine | Heart Trouble/Disease | Pulmonary Shunt/Conduit |
| Alzheimer's disease | Diabetes | Hemophilia | Radiation Treatments |
| Anaphylaxis | Drug Addictions | Hepatitis A B or C | Recent Weight Loss |
| Anemia | Easily Winded | Herpes | Renal Dialysis |
| Angina | Emphysema | High Blood Pressure | Respiratory Problems |
| Arthritis | Epilepsy/Seizures | Hives or Rash | Rheumatic Heart Disease |
| Artificial Heart Valve | Excessive Bleeding | Hypertrophic Cardiomyopathy | Rheumatism |
| Artificial Joint | Excessive Thirst | Hypoglycemia | Scarlet Fever |
| Asthma | Fainting Spells | Irregular Heartbeat | Sexually Transmitted Disease |
| Bacterial Endocarditis | Frequent Cough | Jaundice | Shingles |
| Blood Disease | Frequent Diarrhea | Joint Replacement | Sickle Cell Anemia |
| Blood Transfusion | Frequent Headaches | Kidney Problems | Sinus Trouble |
| Breathing Problem | Genital Herpes | Leukemia | Spina Bifida |
| Bruise Easily | Glaucoma | Liver Disease | Stomach Problems/Ulcers |
| Cancer | Glaucoma | Low Blood Pressure | Stroke |
| Cardiac Pacemaker | Gout | Lung Disease | Swelling of Limbs |
| Chemotherapy | Hay Fever | Mitral Valve Prolapse | Thyroid Problems |
| Chest Pains | Hay Fever/Allergies | Pain in Jaw Joints | Tonsillitis |
| Cold Sores/Fever Blisters | Heart Attack/Failure | Parathyroid Disease | Tuberculosis |
| Congenital Heart Disease | Heart Murmur | Prosthetic Heart Valves | Tumors or Growths |
| Convulsions | Heart Pace Maker | Psychiatric Care | Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, Please explain: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing false information may be dangerous to my health. I understand that it is my responsibility to inform Wilkinson Dental office of any changes in my medical status. I understand dental records are the property of the Dentist and I authorize the release of any or all information including but not limited to the diagnosis and records of any treatment rendered to me or my dependents during the period of Dental Care to third party payors and /or health practitioners.

X _____ Date: _____
 Signature of patient (or parent/legal guardian, if minor)

 Relationship to patient