PATIENT NAME: ____

PREFERRED PHARMACY: ______________________________________

Although dental personnel treat primarily in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questionnaire.

Are you ***ALLERGIC*** to any of the following?

Aspirin	Codeine	Penicillin/Amoxicillin	Cleocin
Latex	Percocet	Vicodin	Sulfa

Please list any other allergies____

Are you currently on any blood thinners? No_____ Yes (please list):____________________________

Have you taken Fosamax (Alendronate), Actonel (Risedronate), or Boniva (Ibandronate)? If yes, how long? _________

Have you taken Cortisone (Steroids) in the last 30 days? No _____ Yes _____

Do you have any of the following?

☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Bacterial Endocarditis
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Coumadin Usage
☐ Congenital Heart Disease
☐ Cortisone Medication
☐ Diabetes
☐ Drug Addiction
☐ Emphysema
☐ Excessive Bleeding
☐ Epilepsy/Seizures
☐ Fainting Spells/Dizziness
☐ Heart Attack/Failure
☐ Heart Disease
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ Hives/Rash
☐ HIV/AIDs
☐ Hypoglycemia
☐ Irregular Heart Beat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Migraine Headaches
☐ Pregnant
☐ Radiation Therapy
☐ Rheumatic Fever
☐ Sinus Problems
☐ Smoker/Chewing Tobacco
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling Of Limbs
☐ Thyroid Disease
☐ TMJ Problems
☐ Tuberculosis
☐ Tumors/Growth

VOYICH Dental Arts VOYICH

Have you been recently informed by a physician to take Pre-Medication prior to dental appointments?

□ No □ Yes

Please list any current medications: ____

Do you have any serious illness which is not listed above? □ No □ Yes (please explain): ____________________

____

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 health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Responsible Party: ______________________________ **Date:** ________________