Merrimack Dental Associates

Patient Name: _____ Birth date: _____ Today's Date: _____

Are you under a physician's care now? 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 taking any medications, pills, or drugs? Yes / No If yes, please complete prescription medication list

Do you take, or have you taken, Phen-Fen or Redux? Yes / No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes / No

Are you on a special diet? Yes / No

Do you use tobacco? Yes / No

Do you use controlled substances? Yes / No

Women: Are you...

Pregnant/Trying to get pregnant? Yes / No

Taking oral contraceptives? Yes / No

Nursing? Yes / No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex

☐ Local Anesthetics ☐ Acrylic ☐ Metal

☐ Sulfa drugs ☐ Other _____

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

AIDS/HIV Positive	Yes / No	Cortisone Medicine	Yes / No	Hemophilia	Yes / No	Radiation Treatments	Yes / No
Alzheimer's Disease	Yes / No	Diabetes	Yes / No	Hepatitis A	Yes / No	Recent Weight Loss	Yes / No
Anaphylaxis	Yes / No	Drug Addiction	Yes / No	Hepatitis B or C	Yes / No	Renal Dialysis	Yes / No
Anemia	Yes / No	Herpes	Yes / No	Rheumatic Fever	Yes / No	Angina	Yes / No
Emphysema	Yes / No	High Blood Pressure	Yes / No	Rheumatism	Yes / No	Arthritis	Yes / No
Epilepsy or Seizures	Yes / No	High Cholesterol	Yes / No	Scarlet Fever	Yes / No	Artificial Heart Valve	Yes / No
Excessive Bleeding	Yes / No	Hives or Rash	Yes / No	Shingles	Yes / No	Artificial Joint	Yes / No
Excessive Thirst	Yes / No	Hypoglycemia	Yes / No	Sickle Cell Disease	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	Spina Bifida	Yes / No	Blood Transfusion	Yes / No
Frequent Diarrhea	Yes / No	Leukemia	Yes / No	Stomach/Intestinal Disease	Yes / No	Breathing Problems	Yes / No
Frequent Headaches	Yes / No	Liver Disease	Yes / No	Stroke	Yes / No	Bruise Easily	Yes / No
Low Blood Pressure	Yes / No	Swelling of Limbs	Yes / No	Cancer	Yes / No	Glaucoma	Yes / No
Lung Disease	Yes / No	Thyroid Disease	Yes / No	Chemotherapy	Yes / No	Hay Fever	Yes / No
Mitral Valve Prolapse	Yes / No	Tonsillitis	Yes / No	Chest Pains	Yes / No	Heart Attack/Failure	Yes / No
Osteoporosis	Yes / No	Tuberculosis	Yes / No	Cold Sores/Fever Blisters	Yes / No	Heart Murmur	Yes / No
Tumors or Growths	Yes / No	Congenital Heart Disorder	Yes / No	Heart Pacemaker	Yes / No	Parathyroid Disease	Yes / No
Ulcers	Yes / No	Convulsions	Yes / No	Heart Trouble/Disease	Yes / No	Psychiatric Care	Yes / No
Venereal Disease	Yes / No	Yellow Jaundice	Yes / No	Acid Reflux	Yes / No	Gout	Yes / No
Vertigo	Yes / No	Back/Neck Pain	Yes / No	Anxiety/Depression	Yes / No		

Have you ever had any serious illness not listed above? Yes / No If 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 (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 _____ Date: _____