Murdoch & Geary Dental

Name: ____________________ Date of Birth: ____________ Today's Date: ____________

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 you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you taking any medications?	Y N	If yes, please list below:	
Are you under a physicians care now?	Y N	If yes:	
Have you ever been hospitalized or had a major operation?	Y N	If yes:	
Do you use tobacco?	Y N	If yes:	
Do you use controlled substances?	Y N	If yes:	

Women are you?

Pregnant/trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other: ____________________

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

AIDS/HIV Positive	Y N	Drug Addiction	Y N	Osteoporosis	Y N	Alzheimer's/ Dementia	Y N
Pain in Jaw Joints	Y N	Epilepsy or Seizures	Y N	Psychiatric Care	Y N	Bleeding Issues	Y N
Arthritis/Gout	Y N	Fainting Spells/Dizziness	Y N	Artificial Joint	Y N	Frequent Headaches	Y N
Asthma/Breathing Issues	Y N	Blood Pressure Issues	Y N	Pacemaker	Y N	Sinus Trouble	Y N
Sleep Apnea	Y N	Hepatitis B or C	Y N	Snoring	Y N	Cancer/Tumors	Y N
Stomach/Intestinal Disease	Y N	Chemotherapy/ Radiation	Y N	High Cholesterol	Y N	Stroke	Y N
Chest Pains	Y N	Swelling of Limbs	Y N	Cold Sores/Fever Blisters	Y N	Thyroid Disease	Y N
Kidney Issues/Dialysis	Y N	Daytime Sleepiness	Y N	Lung Issues	Y N	Oral Herpes	Y N
Heart Disease/Surgery	Y N	Hives or Rash	Y N	Hard of Hearing	Y N	Diabetes/Blood Sugar Issues	Y N

Do you have any condition or illness not listed above? Y N 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: ____________