Legacy Dental Health History

Please circle Yes or No. If yes, please explain.

Are you under a physician's care now? Yes/No_____

Have you ever been hospitalized or had a major operation? Yes/No_____

Are you taking any medication, pills or drugs? Yes/No_____

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_____

Have you ever had a serious head or neck injury? Yes/No_____

Do you or have you ever used tobacco? Yes/No_____

Do you use controlled substances? Yes/No_____

Do you drink alcohol? If yes, how often? Yes/No_____

Women, are you pregnant, trying to get pregnant or Nursing? Yes/No_____

Are you allergic to any of the following? If yes, please circle:

Aspirin Penicillin Codeine Acrylic Metal

Latex Sulfa drugs Local anesthetics Other:_____

Do you have, or have you had, any other the following? Please circle any that apply:

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Breathing Problems
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
Hepatitis A, B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed above? _____

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

_____ _____

Signature of Patient, Parent or Guardian Date Signature of Dentist Date