BONHAM FAMILY DENTISTRY -

PATIENT NAME:______________________________ DATE:____________________
DATE OF BIRTH:__________ AGE: ______

PHYSICIAN NAME:________________________ PHYSICIAN PHONE:__________________

YOUR CURRENT PHYSICAL HEALTH IS: GOOD [ ] FAIR [ ] POOR [ ]

PLEASE LIST ALL CURRENT MEDICATIONS (OR ATTACH A LIST)
1)________________ 2)________________ 3)________________
4)________________ 5)________________ 6)________________
7)________________ 8)________________ 9)________________

HAVE YOU EVER HAD A SURGERY WHERE ARTIFICIAL DEVICES (ie. PINS, RODS, JOINTS, VALVES, etc.) WERE PLACED?
YES NO
IF YES PLEASE GIVE DETAILS: ____

Please Circle Yes or No:
Are you under a physician's care now? YES NO If YES, please explain: ________________
Have you ever been hospitalized or had major surgery? YES NO If YES, please explain: __________
Have you ever had a serious head or neck injury? YES NO If YES, please explain: __________
Do you take, or have you taken Phen-Fen or Redux? 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 Anesthetic
Other: ____

Comments:____

WOMEN: Are you…
Pregnant Trying to get pregnant Nursing Taking oral contraceptives
Do you have…
Osteoporosis Are you taking medication for Osteoporosis? ? YES ? NO
If YES, what medication:____

Do you have, or have you had, any of the following?
AIDS/HIV Positive___ Chest Pain___ Frequent Headaches___ Irregular Heartbeat___ Scarlet Fever___
Alzheimer's Disease___ Cold Sores/Fever Blisters___ Genital Herpes___ Kidney Problems___ Shingles___
Anaphylaxis___ Congenital Heart Disorder___ Glaucoma___ Leukemia___ Sickle Cell Disease___
Anemia___ Convulsions___ Hay Fever___ Liver Disease___ Sinus Trouble___
Angina___ Cortisone Medicine___ Heart Attack/Failure___ Low Blood Pressure___ Spina Bifida___
Arthritis/Gout___ Diabetes___ Heart Murmur___ Lung Disease___ Stomach/Intestinal Disease___
Artificial Heart Valve___ Drug Addiction___ Heart Pacemaker___ Mitral Valve Prolapse___ Stroke___
Artificial Joint___ Easily Winded___ Heart Trouble/Disease___ Pain in Jaw Joint/TMJ___ Swelling in Limbs___
Asthma___ Emphysema___ Hemophilia___ Parathyroid Disease___ Thyroid Disease___
Blood Disease___ Epilepsy/Seizures___ Hepatitis A___ Psychiatric Care___ Tonsillitis___
Blood Transfusion___ Excessive Bleeding___ Hepatitis B or C___ Radiation Treatment___ Tuberculosis___
Breathing Problem___ Excessive Thirst___ Herpes___ Recent Weight Loss___ Tumors or Growths___
Bruise Easily___ Fainting Spells/Dizziness___ High Blood Pressure___ Renal Dialysis___ Ulcers___
Cancer ___ Frequent Cough___ Hives or Rash___ Rheumatic Fever___ Venereal Disease___
Chemotherapy___ Frequent Diarrhea___ Hypoglycemia___ Rheumatism___ Yellow Jaundice___
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 my medical status.

Signature of Patient, Parent, or Guardian Date
____________________ ____________