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

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, pill, or drugs? 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
Do you use controlled substances? Yes No
WOMEN:
Are you pregnant/trying to get pregnant: _____ Taking oral contraceptives: _____ Nursing: _____

Are you allergic to any of the following?
Aspirin: __ Penicillin: __ Codeine: __ Acrylic: __ Metal: __ Latex: __ Local Anesthetics: __

Any other possible allergies:
_____

Do you have any of the following?

AIDS/HIV Positive:	Yes	No	Arthritis/Gout:	Yes	No
Alzheimer's Disease:	Yes	No	Artificial Heart Valve:	Yes	No
Anaphylaxis:	Yes	No	Artificial Joint:	Yes	No
Anemia:	Yes	No	Asthma:	Yes	No
Angina:	Yes	No	Blood Disease:	Yes	No

Blood Transfusion:	Yes	No	Hives or Rash:	Yes	No
Breathing Problems:	Yes	No	Hypoglycemia:	Yes	No
Bruise Easily:	Yes	No	Irregular Heartbeat:	Yes	No
Cancer:	Yes	No	Kidney Problems:	Yes	No
Chemotherapy:	Yes	No	Leukemia:	Yes	No
Chest Pains:	Yes	No	Liver Disease:	Yes	No
Cold Sores/Blisters:	Yes	No	Low Blood Pressure:	Yes	No
Congenital Heart Dis.:	Yes	No	Lung Disease:	Yes	No
Convulsions:	Yes	No	Mitral Valve Prolapse:	Yes	No
Cortisone Medicine:	Yes	No	Pain in Jaw Joints:	Yes	No
Diabetes:	Yes	No	Parathyroid Disease:	Yes	No
Drug Addiction:	Yes	No	Psychiatric Care:	Yes	No
Easily Winded:	Yes	No	Radiation Treatments:	Yes	No
Emphysema:	Yes	No	Recent Weight Loss:	Yes	No
Epilepsy or Seizures:	Yes	No	Renal Dialysis:	Yes	No
Excessive Bleeding:	Yes	No	Rheumatic Fever:	Yes	No
Excessive Thirst:	Yes	No	Rheumatism:	Yes	No
Fainting Spells/Dizzy:	Yes	No	Scarlet Fever:	Yes	No
Frequent Cough:	Yes	No	Shingles:	Yes	No
Frequent Diarrhea:	Yes	No	Sickle Cell:	Yes	No
Frequent Headaches:	Yes	No	Sinus Trouble:	Yes	No
Genital Herpes:	Yes	No	Spina Bifida:	Yes	No
Glaucoma:	Yes	No	Stomach/Intestinal:	Yes	No
Hay Fever:	Yes	No	Stroke:	Yes	No
Heart Attack/Failure:	Yes	No	Swelling of Limbs:	Yes	No
Heart Disease:	Yes	No	Thyroid Disease:	Yes	No
Heart Murmur:	Yes	No	Tonsillitis:	Yes	No
Heart Pace Maker:	Yes	No	Tuberculosis:	Yes	No
Hemophilia:	Yes	No	Tumors or Growths:	Yes	No
Hepatitis A:	Yes	No	Ulcers:	Yes	No
Hepatitis B/C:	Yes	No	Venereal Disease:	Yes	No
Herpes:	Yes	No	Yellow Jaundice:	Yes	No
High BP:	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 the patient's) health. It is my responsibility to inform Nolan River Dental Center of any changes in medical status.

_____

Patient/Guardian Signature Date

Drs. Brian & Amy Case
503 N. Nolan River Rd • Cleburne, Texas 76033
(817) 517-6453
www.nolanriverdentalcenter.com