Moore Family Dental 2022

Patient Name: Birth Date: Date Created:

Disclaimer

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.

Name of Primary Care Physician	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Do you use tobacco or marijuana?	◯ Yes ◯ No	If yes	
Have you recieved the Covid-19 vaccine?	◯ Yes ◯ No	If yes	
Are you currently taking any blood thinners?	◯ Yes ◯ No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Ibuprophen	☐ Metal	☐ Sulfa Drugs
☐ Acrylic	☐ Latex	☐ Milk	☐ Tetracycline
☐ Codeine	☐ Local Anesthetics	☐ Penicillin	☐ Tylenol

Are you allergic to any medications not listed above?	◯ Yes ◯ No	If yes	
Do you require and inhaler/EpiPen?	◯ Yes ◯ No	If yes	

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

AIDS/HIV Positive ◯ Yes ◯ No	Covid-19 ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Hives or rash ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Shingles/Chicken Pox ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Infective Endocarditis ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Kidney Disease ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Fibromylagia ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Multiple Sclerosis (MS) ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No
Cerebral Palsy ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumor or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Condition ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Parkinson's Disease ◯ Yes ◯ No	Venerial Disease ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Vertigo ◯ Yes ◯ No
Cortisone Medication ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	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:_____