Freeman Dental Associates
Cosmetic & General Dentistry

Although dental personnel may primarily treat the area in and around your mouth, we must also consider your overall health to provide the best possible care. Please include any health problems that you may have or medication that you are taking.

Are you under a physician's care now (other than routine)?	Yes / No	If yes, explain:
Have you ever been hospitalized or had a major operation?	Yes / No	If yes, explain:
Have you ever had a serious head or neck injury?	Yes / No	If yes, explain:
Are you taking any medications, pills or drugs?	Yes / No	If yes, explain:
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biphosphates?	Yes / No	If yes, explain:
Do you use tobacco (tobacco, cigarette, chew)?	Yes / No	If yes, explain:

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 (foods, etc.)? If yes, explain:

Do you use controlled substances? If yes, explain:

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

AIDS/HIV Positive	Yes/No	Cortisone Steroid Medicine	Yes/No	Hemophilia	Yes/No	Radiation Treatments	Yes/No
Alzheimer's Disease	Yes/No	Diabetes	Yes/No	Hepatitis A	Yes/No	Recent Weight Loss	Yes/No
Anaphylaxis	Yes/No	Drug Addiction	Yes/No	Hepatitis B	Yes/No	Renal Dialysis	Yes/No
Anemia	Yes/No	Herpes	Yes/No	Hepatitis C	Yes/No	Angina	Yes/No
Emphysema	Yes/No	High Blood Pressure	Yes/No	Rheumatic Fever	Yes/No	Arthritis	Yes/No
Epilepsy or Seizures	Yes/No	High Cholesterol	Yes/No	Rheumatoid Arthritis	Yes/No	Excessive Bleeding	Yes/No
Hives or Rash	Yes/No	Shingles	Yes/No	Artificial Heart Valve	Yes/No	Excessive Thirst	Yes/No
Hypoglycemia	Yes/No	Sickle Cell Disease	Yes/No	Artificial Joint	Yes/No	Fainting Spells/Dizziness	Yes/No

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Irregular Heartbeat	Yes/No	Sinus Trouble	Yes/No	Asthma	Yes/No	Kidney Problems	Yes/No
Blood Transfusion	Yes/No	Leukemia	Yes/No	Blood Disease	Yes/No	Breathing Problems	Yes/No
Frequent Headaches	Yes/No	Liver Disease	Yes/No	Stomach/Intestinal Disease	Yes/No	Bruise Easily	Yes/No
Low Blood Pressure	Yes/No	Swelling of Limbs	Yes/No	Stroke	Yes/No	Glaucoma	Yes/No
Lung Disease	Yes/No	Thyroid Disease	Yes/No	Cancer	Yes/No	Mitral Valve Prolapse	Yes/No
Tonsillitis	Yes/No	Chest Pains	Yes/No	Chemotherapy	Yes/No	Osteoporosis	Yes/No
Tuberculosis	Yes/No	Cold Sores/Fever Blisters	Yes/No	Heart Attack/Failure	Yes/No	Pain in Jaw Joints	Yes/No
Tumors or Growths	Yes/No	Congenital Heart Disorder	Yes/No	Heart Murmur	Yes/No	Parathyroid Disease	Yes/No
Ulcers	Yes/No	Heart Trouble/Disease	Yes/No	Heart Pacemaker	Yes/No	STD	Yes/No
Arthritis	Yes/No	Gout	Yes/No	Psychiatric Care	Yes/No		Yes/No

Dental History:

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

Signature of Patient, Parent or Guardian: Date:

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