Montana Roots Dental Care

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Are you under the care of a physician? ◯ Yes ◯ No

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No

Have you ever had a serious head or neck injury? ◯ Yes ◯ No

Are you taking any medications, pills or drugs? ◯ Yes ◯ No

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No

Do you or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No

What Medications Are you Currently Taking? *

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_____

_____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Has a physician or previous dentist recommended that you take antibiotics or pre-medication prior to your dental appointment?
◯ Yes ◯ No

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 Anesthetic

Do you have any other known allergies? ◯ Yes ◯ No

Do you have or have you had any of the following diseases or medical conditions?

☐ No to all	☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss	☐ Anaphylaxis
☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis	☐ Anemia	☐ Easily Winded
☐ Herpes	☐ Rheumatic Fever	☐ Angina	☐ Emphysema	☐ High Blood Pressure
☐ Rheumatism	☐ Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artifical Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles	☐ Artifical Joint
☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease	☐ Asthma	☐ Fainting Spells/Dizziness
☐ Irregular Heart Beat	☐ Sinus Trouble	☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems
☐ Spina Bifida	☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke	☐ Bruise Easily
☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs	☐ Cancer	☐ Glaucoma
☐ Lung Disease	☐ Thyroid Disease	☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse
☐ Tonsillitis	☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths	☐ Congenital Heart Disorder
☐ Pacemaker	☐ Parathyroid Disease	☐ Ulcers	☐ Convulsions	☐ Heart Trouble/Disease
☐ Psychiatric Care	☐ Venereal Disease	☐ Yellow Jaundice		

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

If yes, please list any serious illness: *

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_____

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_____

Response Date: _____