WM. BLAINE RUDISILL, DMD, PA

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.

Do you have a goal today at the Dental Office? What would you like to accomplish? Please elaborate:	◯ Yes ◯ No	If yes
How did you hear about us; patient, location, etc.		
Are you currently in Pain? If yes, for how long have you been in pain, and how did it start? Please elaborate:	◯ Yes ◯ No	If yes
What medications are you taking and for what reason?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation? If yes, what type and when?	◯ Yes ◯ No	If yes
Do you use or have you used tobacco products? What type and for how long?	◯ Yes ◯ No	If yes
Do you use any controlled substances? If yes, for what condition?	◯ Yes ◯ No	If yes
Do you have a Pace Maker?	◯ 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 Anesthetics
☐ Food	☐ Other		

If yes to food or other, please elaborate.	◯ Yes ◯ No	If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Excessive bleeding	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Fainting or Dizziness	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Irregular Heatbeat	◯ Yes ◯ No	Tumors or Growths	◯ 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:_____