PONY EXPRESS
FAMILY DENTISTRY

513 10th Street, Gothenburg, Nebraska 69138
(308) 537-7195
Dr. Audrey N. Aden

PATIENT NAME _____ Birth Date _____

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
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
Have you ever had a serious head or neck injury? ☐ Yes ☐ No
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates (for osteoporosis)? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you used controlled substances? ☐ Yes ☐ No
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please list:

Name of Medication	Dose	Frequency	Reason

Are you allergic to any medications (prescription or over the counter), latex, iodine, etc? ☐ Yes ☐ No If yes, please list:

_____

_____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatment	Yes	No	Have you ever had any serious illness not listed above?		
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 or C	Yes	No	Renal Dialysis	Yes	No			
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatoid Fever	Yes	No			
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No			
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No			
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives/Rash	Yes	No	Shingles	Yes	No			
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No			
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No			
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No			
Blood Thinners	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Int. Disease	Yes	No			
Blood Transfusion	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No			
Breathing Problem	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No			
Bruise Easily	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No			
Cancer	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No			
Chemotherapy	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No			
Chest Pains	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors/Growths	Yes	No			
Cold Sores/Fever Blisters	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No			
Congenital Heart Disorder	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No			
Convulsions	Yes	No							Yellow Jaundice	Yes	No			

Yes No
Comments (please explain any answered 'Yes' to the above questions):_____

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_____

Women Only: Are you:
Pregnant/Trying to get pregnant? Yes ☐ No ☐ Taking oral contraceptives? Yes ☐ No ☐ Nursing? Yes ☐ No ☐

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 _____ DATE _____