Don Henson, D.D.S.
6230 Highland Place Way, Suite 202
Knoxville, TN 37919
865-588-0578

Patient Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems you may have, or medication you may be taking, could have an important interrelationship with the treatment received.

Are you under a physician's care now?	○Yes ○No	Explain: _____
Have you ever been hospitalized or had a major operation?	○Yes ○No	Explain: _____
Have you ever had a serious head or neck injury?	○Yes ○No	Explain: _____
Are you taking any medications, pills, or drugs?	○Yes ○No	Explain: _____
Do you take, or have you taken: Phen-Fen or Redux?	○Yes ○No	Explain: _____
Have you ever taken Fosamax, Boniva, Actonel, or any other meds containing bisphosphates?	○Yes ○No	Explain: _____
Are you on a special diet?	○Yes ○No	Explain: _____
Do you use tobacco?	○Yes ○No	Explain: _____
Do you use controlled substances?	○Yes ○No	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

Explain: _____

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

○ AIDS/ HIV Positive	○ Cortisone Medicine	○ Hemophilia	○ Radiation Treatment
○ 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
○ Arthritis/ Gout	○ Epilepsy or Seizures	○ High Cholesterol	○ Scarlet Fever
○ Artificial Heart Valve	○ Excessive Bleeding	○ Hives or Rash	○ Shingles
○ Artificial 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 Problem	○ 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	○ Osteoporosis	○ Tuberculosis
○ Cold Sores/Fever Blisters	○ Heart Murmur	○ Pain in Jaw Joints	○ Tumors or Growths
○ Congen. Heart Disorder	○ Heart Pacemaker	○ Parathyroid Disease	○ Ulcers
○ Convulsions	○ Heart Trouble/ Disease	○ Psychiatric Care	○ Venereal Disease
Other: _____			○ Yellow Jaundice

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: _____ Date:_____