Houston Oral Healthcare Specialists

Lewis C Cummings DDS MS

Are you under a physicians care now? Yes ____ No ____ If yes, _____
Have you ever been hospitalized or had a major operation? Yes_____ No____ If yes, _____
Have you ever had a serious head or neck injury? Yes_____ No ____ If yes, _____
Are you taking any medications, pills, or drugs? Yes_____ No ____ If yes, _____
Have you ever taken Fosamax, Boniva, Actonel or any other
Medications containing bisphosphonates? Yes_____ No _____ If yes, _____
Are you on a special diet? Yes ____ No _____
Do you use tobacco? Yes _____ No _____
Do you use controlled substances? Yes_____ No _____ If yes, _____

Women? (Please check if yes)
Pregnant/Trying to get pregnant? _____ Nursing?_____ Taking oral contraceptives? _____

Are you allergic to any of the following? (Please check if yes)

Aspirin____	Penicillin____	Codeine____	Acrylic____
Metal____	Latex____	Sulfa Drugs____	Local Anesthesia____
Other____	If yes, _____		

Have you ever had any serious illness not listed above? Yes_____ No_____ If yes, _____

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

AIDS/HIV positive	Yes__ No__	Cortisone Medicine	Yes__ No__	Hemophilia	Yes__ No__	Radiation	Yes__ No__
Alzheimer Disease	Yes__ No__	Diabetes	Yes__ No__	Hepatitis A	Yes__ No__	Anaphylaxis	Yes__ No__
Drug Addiction	Yes__ No__	Hepatitis B or C	Yes__ No__	Renal Dialysis	Yes__ No__	Anemia	Yes__ No__
Herpes	Yes__ No__	Rheumatic 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__	Artificial Heart Valve	Yes__ No__	Excessive Bleeding	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/ Dizzy	Yes__ No__	Irregular Heartbeat	Yes__ No__	Sinus Trouble	Yes__ No__
Blood Disease	Yes__ No__	Kidney Problems	Yes__ No__	Spina Bifida	Yes__ No__	Blood Transfusion	Yes__ No__
Leukemia	Yes__ No__	Stomach/Intestine Disease	Yes__ No__	Breathing Problems	Yes__ No__	Frequent Headaches	Yes__ No__
Liver Disease	Yes__ No__	Stroke	Yes__ No__	Bruise Easily	Yes__ No__	Genital Herpes	Yes__ No__
Low Blood Pressure	Yes__ No__	Cancer	Yes__ No__	Glaucoma	Yes__ No__	Lung Disease	Yes__ No__
Thyroid Disease	Yes__ No__	Chemotherapy	Yes__ No__	Mitral Valve	Yes__ No__	Tonsillitis	Yes__ No__
Chest Pains	Yes__ No__	Heart Attack/Failure	Yes__ No__	Osteoporosis	Yes__ No__	Tuberculosis	Yes__ No__
Cold Sores	Yes__ No__	Jaw Joint Pain	Yes__ No__	Tumors/Growths	Yes__ No__	Congenital Heart Disorder	Yes__ No__
Pacemaker	Yes__ No__	Parathyroid Disease	Yes__ No__	Ulcers	Yes__ No__	Convulsions	Yes__ No__
Heart Disease	Yes__ No__	Psychiatric Care	Yes__ No__	Venereal Disease	Yes__ No__	Blood Thinners	Yes__ No__

For Staff Use Only BP: _____ Pulse: _____ Weight: _____ Height: _____

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: _____