

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

**INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT THE PRESENT (CIRCLE SEPERATELY)**

<i>Heart Attack</i>	YES	NO	<i>Artificial Joints (hips, knees, etc.)</i>	YES	NO	<i>Hepatitis B</i>	YES	NO
<i>Angina Pectoris</i>	YES	NO	<i>Kidney Trouble</i>	YES	NO	<i>Hepatitis C</i>	YES	NO
<i>Heart Disease</i>	YES	NO	<i>Ulcers</i>	YES	NO	<i>Venereal Disease</i>	YES	NO
<i>Heart Murmur</i>	YES	NO	<i>Diabetes</i>	YES	NO	<i>H.I.V. and/or AIDS</i>	YES	NO
<i>High Blood Pressure</i>	YES	NO	<i>Thyroid Problems</i>	YES	NO	<i>Cold Sores</i>	YES	NO
<i>Arteriosclerosis</i>	YES	NO	<i>Glaucoma</i>	YES	NO	<i>Blood Transfusion</i>	YES	NO
<i>Mitral Valve Prolapse</i>	YES	NO	<i>Emphysema</i>	YES	NO	<i>Hemophilia</i>	YES	NO
<i>Artificial Heart Valve</i>	YES	NO	<i>Chronic Cough</i>	YES	NO	<i>Anemia</i>	YES	NO
<i>Heart Pacemaker</i>	YES	NO	<i>Tuberculosis</i>	YES	NO	<i>Sickle Cell Disease</i>	YES	NO
<i>Heart Surgery</i>	YES	NO	<i>Asthma</i>	YES	NO	<i>Bruise Easily</i>	YES	NO
<i>Stroke</i>	YES	NO	<i>Latex Allergy</i>	YES	NO	<i>Liver Disease</i>	YES	NO
<i>Rheumatic Fever</i>	YES	NO	<i>Hay Fever</i>	YES	NO	<i>Yellow Jaundice</i>	YES	NO
<i>Arthritis</i>	YES	NO	<i>Allergies or Hives</i>	YES	NO	<i>Osteoporosis</i>	YES	NO
<i>Rheumatism</i>	YES	NO	<i>Sinus Trouble</i>	YES	NO	<i>Epilepsy or Seizures</i>	YES	NO
<i>Pain in Jaw Joints</i>	YES	NO	<i>Radiation Therapy</i>	YES	NO	<i>Fainting or Dizzy Spells</i>	YES	NO
<i>Drug Addiction</i>	YES	NO	<i>Chemotherapy</i>	YES	NO	<i>Nervousness</i>	YES	NO
						<i>Psychiatric Treatment</i>	YES	NO

1. Has there been any change in your general health within the past year? ..... YES NO
2. Date of last physical \_\_\_\_\_.
3. Are you now under the care of a physician? ..... YES NO
4. Physician's name, address and telephone number \_\_\_\_\_
5. a. Are you taking any medication, pills or drugs (including daily aspirin)? ..... YES NO  
If yes, please list: \_\_\_\_\_
- b. Are you taking any vitamins, herbs, or dietary supplements? ..... YES NO  
If yes, please list: \_\_\_\_\_
6. Are you aware of being allergic to or have you ever reacted adversely to:
  - a. Local anesthetics? ..... YES NO
  - b. Penicillin or other antibiotics? ..... YES NO
  - c. Sulfa drugs? ..... YES NO
  - d. Barbiturates, sedatives or sleeping pills? ..... YES NO
  - e. Aspirin? ..... YES NO
  - f. Iodine? ..... YES NO
  - g. Codeine or other narcotics? ..... YES NO
  - h. Other \_\_\_\_\_
7. Do you have chest pain upon exertion? ..... YES NO
8. Are you ever short of breath after mild exercise or while lying down? ..... YES NO
9. Do your ankles swell? ..... YES NO
10. Have you had any serious trouble associated with any previous dental treatment? ..... YES NO  
If so, explain \_\_\_\_\_
11. Do you have any other disease, condition or problem not listed above? ..... YES NO  
If so, explain \_\_\_\_\_
12. Do you smoke or have you smoked in the past? ..... YES NO

**WOMEN**

13. Are you pregnant? ..... YES NO
14. Do you have any problems associated with your menstrual period? ..... YES NO
15. Are you taking birth control pills? ..... YES NO
16. Are you nursing? ..... YES NO

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

Signature of Patient (or guardian)

Date