PATIENT:_____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N) - ALL RESPONSES ARE CONFIDENTIAL

1. Are you in good health?..... Y N
2. Has there been any change in your general health in the past year?..... Y N
3. Date of last physical exam:_____
4. Are you now under a physician's care for a particular problem?..... Y N
5. Have you had any serious illnesses, operations or hospitalizations? If so, describe..... Y N
6. Have you had any adverse effects from dental treatment?..... Y N

DO YOU HAVE OR HAVE YOU EVER HAD:

A. Rheumatic Fever or Rheumatic Heart Disease..... Y N
B. Congenital Heart Disease..... Y N
C. Cardiovascular Disease (Heart Attack, Heart Murmur, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker..... Y N
D. Lung Disease (Asthma, Emphysema, Bronchitis Pneumonia, Tuberculosis, Chest Pain, Shortness of Breath..... Y N
E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Nervous Disorder or Breakdown..... Y N
F. Bleeding Disorder, Anemia, Transfusion, or Bleed Easily..... Y N
G. Liver Disease (Jaundice, Hepatitis)..... Y N
H. Kidney Disease..... Y N
Diabetes..... Y N
I. Thyroid disease..... Y N
J. Stomach ulcers or Colitis..... Y N
K. Glaucoma... Y N
L. Implants placed anywhere in your body (Heart Valve, Hip, Knee)..... Y N
M. Radiation treatment for cancer..... Y N
N. Clicking or popping of jaw joint, pain near the ear, difficulty opening mouth, grind or clench teeth Y N
O. Any disease, drug or transplant operation that has depressed your immune system..... Y N
P. Recurrent Infections of any kind..... Y N

7. **ARE YOU TAKING ANY OF THE FOLLOWING:**

A. Tagamet, Thyroid Medication, Antibiotics? Y N
B. Anticoagulants (Blood thinners)..... Y N
C. High Blood Pressure Medicine..... Y N
D. Steroids (Cortisone, etc)..... Y N
E. Tranquilizers (Valium)..... Y N
F. Insulin, Diabenese, etc..... Y N
G. Digitalis, Inderal,Nitroglycerin, Calcium, Channel Blockers, Procardia, or other heart medicine... Y N
H. Aspirin or Ibuprofen (Motrin,Naprosyn)..... Y N
How much daily?_____
I. Marijuana or other "Street Drugs"..... Y N
J. Antihistamines or decongestants (Seldane)..... Y N
K. Pamidronate (Aredia), Zoledronate (Zometa)..... Y N
Alendronate (Fosamax)?..... Y N

8. Are you taking any other regular medications, pills, or drugs?..... Y N
If yes, Please list:_____
_____

9. Are you **allergic to** or have you ever had a reaction to:
A. Local anesthetic (Novocaine, etc.)..... Y N
B. Penicillin, Amoxicillin, Cephalosporins or other antibiotics?..... Y N
C. Barbiturates, Sedatives, etc.?..... Y N
D. Aspirin or Ibuprofen..... Y N
E. Codeine or other Pain Killers..... Y N
F. Latex or Rubber Products..... Y N
G. Other Allergies or Reactions?..... Y N
If Yes, Please List_____

10. Do you smoke or chew tobacco?..... Y N
11. Do you use alcohol frequently?..... Y N
12. Do you have any other condition or problem not listed that you think the doctor should know about?..... Y N

For Women Only:
A. Are you pregnant?..... Y N
B. If you are using oral contraceptives, it is important to understand that antibiotics may interfere with the effectiveness of oral contraceptives. Therefore you will need to use an alternate form of birth control for one complete cycle after the course of antibiotics. Consult with your physician for further guidance.
C. If you are pregnant, or trying to become pregnant surgery, or anesthetics may harm your baby in the first trimester. Please advise your doctor if there is any chance of your being pregnant.
D. Do you wish to have a pregnancy test?..... Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE.

I HAVE BEEN MADE AWARE OF YOUR OFFICES PRIVACY POLICIES AND CAN HAVE A COPY UPON REQUEST.

_____ _____
Signature of patient or legal guardian (if patient is under 18 years old) Date

MEDICAL UPDATE: I have read my health history and confirm that it adequately states past and present conditions.

_____ _____
Patient's Signature Date