

Patient's Name: _____ Date of Birth: _____ Physician's Name and Address: _____ Physician's Phone: _____ Date of your most recent visit to Physician _____ Reason: _____ How would you assess your general Health? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	OFFICIAL USE ONLY Yes No Pre-Med <input type="checkbox"/> <input type="checkbox"/> Comments:
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To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

1. Are you seeing a physician at the present time for the treatment of a recent or ongoing medical condition?	Yes	No	<input type="checkbox"/> <input type="checkbox"/>
2. Have you been hospitalized within the last year? If yes, explain.	Yes	No	<input type="checkbox"/> <input type="checkbox"/>
3. Have you had a serious illness or operation within the last year? If yes, explain.	Yes	No	<input type="checkbox"/> <input type="checkbox"/>
4. Have you ever had any serious medical trouble associated with any dental experience? If yes, explain.	Yes	No	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever been advised to take antibiotics (like penicillin, etc..) before a dental appointment? If yes, explain.	Yes	No	<input type="checkbox"/> <input type="checkbox"/>

Diabetes? If yes, do you require insulin? Type and Dose _____	Yes	No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you have an artificial joint?..... If yes, which joint(s)? _____	Yes	No	<input type="checkbox"/> <input type="checkbox"/>
Hepatitis? If yes, check type: <input type="checkbox"/> Type A <input type="checkbox"/> Other <input type="checkbox"/> Type B <input type="checkbox"/> Non-Specific Type <input type="checkbox"/> Type C <input type="checkbox"/> Don't Know	Yes	No	<input type="checkbox"/> <input type="checkbox"/>
Have you ever required a blood transfusion? If yes, what was the date of the transfusion? _____	Yes	No	<input type="checkbox"/> <input type="checkbox"/>
Are you HIV positive Do you have any reason to suspect that you Have been exposed to the HIV virus? Have you ever had Tuberculosis (TB)?..... Have you ever had a TB test?..... Do you have a cough that has lasted more than 3 week? Do you ever cough up blood?.....	Yes	No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Do you now or have you had any of the following diseases or problems?

Cardiovascular Disease

- If yes, check any that apply:
- | | |
|--|--|
| <input type="checkbox"/> heart disease | <input type="checkbox"/> hardening of the arteries |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> coronary bypass | <input type="checkbox"/> stroke |
| <input type="checkbox"/> angina | <input type="checkbox"/> heart murmur |
| <input type="checkbox"/> mitrol valve prolapse | <input type="checkbox"/> congestive heart failure |

- | | | | |
|---|-----|----|---|
| Rheumatic fever or rheumatic heart disease | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |
| Congenital heart defects | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |
| Prosthetic (artificial) heart valves | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |
| High blood pressure | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |
| High cholesterol | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |
| Are you short of breath after mild exercise? | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |
| Do your ankles swell? | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |
| Do you get short of breath when you lie down? | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |
| Do you have chest pain upon exertion? | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |
| Abnormal bleeding or extended clotting time | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |
| Frequent or unexpected nose bleeds | Yes | No | <input type="checkbox"/> <input type="checkbox"/> |

CHECK ALL THAT APPLY:

- | | |
|---|---|
| <input type="checkbox"/> Allergies
<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Autoimmune Disease
<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chemo Therapy
<input type="checkbox"/> Chronic/Recurring Sinus Problems
<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Drug or Alcohol Treatment
<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Epilepsy or Other Seizures | <input type="checkbox"/> Glaucoma
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Herpes
<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Jaundice or Liver Disease
<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Serious/Frequent Headaches
<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Other _____ |
|---|---|

HEALTH HISTORY

Yes No
Do you consider yourself currently under an abnormally amount of stress?

Have you had any unexplained or unplanned weight loss recently?

When was your last physical exam with your medical doctor, including blood tests?

Do you now or have you ever smoked?
(Please circle) Cigarettes Pipe Cigar Other

If you currently smoke, how much? _____
If ou have smoked in the past but no longer smoke, when did you quit? _____

Do you chew tobacco?
If yes, how often? _____

Do you drink alcohol?
If yes, how much? _____

WOMEN:

Are you currently pregnant?

Expected delivery date _____

Do you have regular gynecological checkups?

Have you reached menopause?

Are you currently on hormone replacement therapy?

Have you had a mammogram?

Date _____

If you are currently taking these medications, check the box on the left. If you have taken any of these medications within the past year, but are not taking them currently, check the box on the right.

Now	Past Year	
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	Antidepressants (Prozac, Zoloft, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure Medicine
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone (Prednisone, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol Medication
<input type="checkbox"/>	<input type="checkbox"/>	Decongestants
<input type="checkbox"/>	<input type="checkbox"/>	Diuretics (water pills)
<input type="checkbox"/>	<input type="checkbox"/>	Hormones (birth control pills, estrogen)
<input type="checkbox"/>	<input type="checkbox"/>	Inhalants
<input type="checkbox"/>	<input type="checkbox"/>	Insulin
<input type="checkbox"/>	<input type="checkbox"/>	Medicine for Heart Problems
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Relaxants
<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerine
<input type="checkbox"/>	<input type="checkbox"/>	Pain Medicine (Aspirin, Advil, Tylenol, etc)
<input type="checkbox"/>	<input type="checkbox"/>	Prescription Pain Medication
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Pills
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Medicine
<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers
<input type="checkbox"/>	<input type="checkbox"/>	Vitamins
<input type="checkbox"/>	<input type="checkbox"/>	Others _____

Are you ALLERGIC to the following medications (do you get hives, a rash, have trouble breathing, etc.):

- Antibiotics (Penicillin, tetracycline, etc.)
- Local Dental Anesthetics (novacaine)
- Codeine
- Aspirin
- Barbituates or Sedatives
- Tranquilizers
- Others _____

Yes No
Have you ever had an adverse reaction like nausea, dizziness, or feeling, "spacey" with any drug or medication?

Do you have any disease, condition or problem not previously listed that you feel we should know about?

Signatures:

Today's Date _____

Notes:

BP:
RESP:
PULSE:

HEALTH HISTORY