MEDICAL HISTORY (ALL RESPONSES ARE KEPT CONFIDENTIAL)

Answer all questions by circling YES (Y) or No (N)

1. Have you ever had any adverse effects from dental treatment? ....Y N
2. Do you wear a denture or removable appliance? Y N
3. Clicking or Popping of the Jaw Joint, Pain Near Ear, Difficulty Opening Mouth, Grind or Clench Teeth?..Y N
4. Have you or a family member had problems with general anesthesia?………………………………Y N
5. Do you snore or have you been diagnosed with sleep apnea?……………………………………………Y N
6. Do you smoke or chew tobacco? ....Y N
7. Do you use Marijuana or other "street drugs"? ....Y N
8. Do you use alcohol?..Y N
9. Are you pregnant or nursing?……………………Y N
   If yes, how many months ______________________
10. Do you wear contact lenses?……………………Y N
11. Are you wearing any oral piercings?……………Y N

Are you taking any of the following medications:
If yes, please indicate name of medication(s).

1. Thyroid Medications..Y N
2. Antibiotics or Sulfa Drugs ....Y N
3. Anticoagulants (Blood Thinners) ....Y N
4. High blood Pressure Medicine............................Y N
5. Steroids (Cortisone, etc.) ....Y N
6. Tranquilizers (Valium, etc.)................................Y N
7. Insulin or Anti-Diabetic drug..............................Y N
8. Digitalis, Inderal, Nitroglycerin,Calcium Channel Blockers, Procardia, or other Heart Medicine? ...Y N
9. Aspirin or Ibuprofen ....Y N
   If so, how much daily ___________________
10. Antihistamines or Decongestants ....Y N

Are you allergic or had a bad reaction to: If answering yes, please circle condition(s).

1. Local Anesthetic (Novocaine, etc.)……………. Y N
2. Penicillin, Amoxicillin, Cephalosporins or other Antibiotics ....Y N
3. Barbiturates, Sedatives, etc. ....Y N
4. Aspirin or Ibuprofen ....Y N
5. Codeine or other Pain Killers ....Y N
6. Latex or Rubber Products ....Y N
7. Eggs ....Y N
8. Soybeans……………………………………….. Y N
9. Sulfa ……………………………………………..Y N
9. Other Allergies or Reactions________________Y N

Do you have or have you ever had: If answering yes, please circle condition(s) that pertains to you.

1. Scarlet or Rheumatic Fever .... Y N
2. Congenital heart disease ……………… Y N
3. Cardiovascular Disease/Heart Condition……Y N
   - Angina……………………………….. Y N
   - Heart murmur…………………………. Y N
   - Heart attack: if yes, when___________ Y N
   - Heart surgery: if yes, when__________ Y N
   - High blood pressure…………………… Y N
   - Low blood pressure…………………… Y N
   - Pacemaker…………………………….. Y N
   - Stroke………………………………….. Y N
4. Lung Disease
   - Asthma…………………………………Y N
   - Emphysema……………………………Y N
   - Bronchitis………………………………Y N
   - Tuberculosis……………………………Y N
   - Shortness of breath……………………. Y N
   - Pneumonia……………………………...Y N
5. Bleeding Disorder
   - Anemia…………………………………Y N
   - Bleed or bruise easily…………………. Y N
6. Nervous Disorder
   - Epilepsy/Seizures…………………….. Y N
   - Fainting ……………………………… Y N
   - Psychiatric treatment………………… Y N
7. Liver Disease (Jaundice, Hepatitis) .... Y N
8. Kidney Disease .... Y N
9. Diabetes .... Y N
10. Thyroid Disease .... Y N
11. Arthritis.. Y N
12. Stomach Ulcers or Colitis .... Y N
13. Glaucoma .... Y N
14. Bone disease
    - Medications ________________________
15. Treatment for Cancer
    - Surgery……………………………… Y N
    - Radiation…………………………….. Y N
    - Chemotherapy……………………….. Y N
    - Oral cancer drugs…………………… Y N
16. Immune System ……………………………. Y N
    - HIV/AIDS…………………………….. Y N
17. Have you had an organ or tissue transplant…Y N
18. Frequent or Recurring Mouth Sores .... .Y N
19. Implants placed anywhere in your body (Heart Valve, Hip, Knee)............................. Y N
20. Sinus or Nasal Problems? .... Y N

- Do you have any other disease or condition not listed above that the doctor should know about?………Y N
  If yes, please list ______________________________
- Do you wish to talk to the doctor privately about anything?.. Y N

For Women Only:

- Antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please advise the doctor if there is any chance of your being pregnant.

MEDICAL DOCTOR ___________________________

HEIGHT _________ **WEIGHT** __________

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

______________ Patient Name

______________________________ Signature of person completing Health History

________________ Doctor's Initials

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PLEASE LIST ALL MEDICATIONS BELOW THAT YOU ARE TAKING

MEDICATION	STRENGTH	FREQUENCY

PATIENT SIGNATURE ______________________ DATE ______________