____ ____

Patients Name **Height** **Weight** **Age**

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

1. Are you in good health?.....Y..... N
2. Have there been any changes in your general health in the last year?.....Y.....N
3. Are you now under a physician's care for any particular problem?.....Y.....N If yes, please list physician's name and phone number.
   ____
4. Have you ever had any serious illnesses, operations, or hospitalizations?.....Y..... N
   If so, describe__________________________
   ____
   ____
5. Date of your last physical exam _____________
6. **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 Surgery, Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Pacemaker)?.....Y.....N
   d. Lung Disease (Asthma, Emphysema, Pneumonia, Tuberculosis, Shortness of Breath)?.....Y.....N
   e. Seizures, Epilepsy, Fainting, or Dizziness?.....Y.....N
   f. Bleeding Disorder, Anemia, Blood Transfusion?.....Y.....N
   g. Do you bruise easily?.....Y.....N
   h. Kidney Disease?.....Y.....N
   i. Diabetes?.....Y.....N
   j. Liver Disease (Jaundice, Hepatitis)?.....Y.....N
   k. Thyroid Disease?.....Y.....N
   l. Arthritis?.....Y.....N
   m. Stomach Ulcers or Colitis?.....Y.....N
   n. Glaucoma?.....Y.....N
   o. Implants places anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?.....Y.....N
   p. Radiation (X-Ray) treatment for cancer?.....Y.....N
   q. Sinus or nasal Problems?.....Y.....N
   r. Any disease, drug, or transplant operation that has depressed your immune system?.....Y.....N
   s. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y.....N
      Is this problem new or old? _____________
7. **Are you using any of the following?**
   a. Antibiotics?.....Y.....N
   b. Anticoagulants (Blood Thinners)?.....Y.....N
   c. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.....Y......N
   d. High Blood Pressure Medicine?.....Y.....N
   e. Steroids (Cortisone, etc.)?.....Y.....N
   f. Have you ever taken (past/present) medicines for Bone Cancer or Osteoporosis?.....Y.....N
   g. Tranquilizers?.....Y.....N
   h. Insulin or Oral Anti-Diabetic drugs?.....Y.....N
   i. Digitalis, Inderal, Nitroglycerin or other heart drugs?.....Y.....N
   j. Please list any and all medications taken, including prescription, over-the-counter, herbal, or holistic remedies, vitamin, or minerals:_______________________________
      ____
      ____
8. **Are you allergic to or have you had an adverse reaction to :**
   a. Local Anesthesia (Novocain, etc.)?.....Y.....N
   b. Penicillin or other antibiotics?.....Y.....N
   c. Sedatives, Barbiturates?.....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
      Please list__________________________
      ____
      ____
9. Do you smoke or chew Tobacco?.....Y.....N
   If yes, how much per day and for how many years?
   ____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide for you?.....Y.....N
11. Have you had any serious problems associated with any previous dental Treatment?.....Y.....N
12. Have you or an immediate family member had any problems associated with intravenous anesthesia?.....Y.....N
13. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?.....Y.....N
14. **For women only**
    a. Are you pregnant or is there any chance you might be pregnant?.....Y.....N
    b. Are you nursing?.....Y.....N
    c. If you are on Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one cycle of birth control pills, after the course of the antibiotics or other medication is completed. Please consult with your physician for further guidance.

______________________________ _____________

Signature of person completing Form Date