PLEASE PRINT

PATIENT'S NAME	SEX	AGE	BIRTH DATE	HEIGHT	WEIGHT

PHYSICIAN'S NAME	REFERRING DENTIST'S NAME	REASON FOR VISIT

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

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
   IF SO, WHAT FOR? _____
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
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. CARDIOVASCULAR DISEASE, HEART DISEASE? Y N
   - B. HEART MURMUR OR RHEUMATIC HEART DISEASE? Y N
   - C. ANGINA, CHEST PAIN, OR STROKE? Y N
   - D. HIGH BLOOD PRESSURE? Y N
   - E. HEART PACEMAKER OR HEART SURGERY? Y N
   - F. LUNG DISEASES, TUBERCULOSIS? Y N
   - G. ASTHMA? Y N
   - H. EMPHYSEMA, BRONCHITIS, PNEUMONIA? Y N
     _____
   - I. SHORTNESS OF BREATH, SLEEP APNEA? Y N
   - J. SEIZURES, EPILEPSY, CONVULSIONS? Y N
   - K. FAINTING, DIZZINESS? Y N
   - L. NERVOUS DISORDER OR BREAKDOWN, PSYCHIATRIC TREATMENT Y N
   - M. BLEEDING DISORDER, ANEMIA, BLEEDING TENDENCY, BLOOD TRANSFUSION, DO YOU BRUISE EASILY? Y N
     _____
   - N. LIVER DISEASE (JAUNDICE, HEPATITIS)? Y N
   - O. KIDNEY DISEASE? Y N
   - P. DIABETES? Y N
   - Q. THYROID DISEASE (GOITER)? Y N
   - R. ARTHRITIS OR BONE DISEASES? Y N
   - S. STOMACH ULCERS OR COLITIS? Y N
   - T. GLAUCOMA OR EYE DISEASES? Y N
   - U. IMPLANTS PLACED ANYWHERE IN YOUR BODY (HEART VALVE, HIP, KNEE)? Y N
   - V. RADIATION (X-RAY) TREATMENT FOR CANCER? Y N
   - W. CLICKING OR POPPING OF JAW JOINT? Y N
     DIFFICULTY OPENING MOUTH, GRIND OR CLENCH TEETH? Y N
     _____
   - X. SINUS OR NASAL PROBLEMS? Y N
   - Y. ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM? Y N
   - Z. RECURRENT MOUTH SORES OR BODY INFECTIONS? Y N

DOCTOR'S NOTES

ALL RESPONSES ARE KEPT CONFIDENTIAL

8. ARE YOU USING OR TAKING ANY OF THE FOLLOWING:
   - A. THYROID MEDICATIONS? Y N
   - B. ANTIBIOTICS OR SULFA DRUGS? Y N
   - C. ANTICOAGULANTS (BLOOD THINNERS)? Y N
   - D. HIGH BLOOD PRESSURE MEDICINE? Y N
   - E. STEROIDS (CORTISONE, ETC.)? Y N
   - F. TRANQUILIZERS (VALIUM, XANAX, ETC.)? Y N
   - G. INSULIN, DIABENESE, OR SIMILAR DRUG? Y N
   - H. DIGITALIS, NITROGLYCERIN, CALCIUM CHANNEL BLOCKERS, OR OTHER HEART MEDICINE? Y N
   - I. ASPIRIN OR IBUPROFEN? Y N
     HOW MUCH DAILY?
   - J. MARIJUANA OR OTHER "STREET" DRUGS? Y N
   - K. ANTIHISTAMINES OR DECONGESTANTS? Y N
   - L. **ARE YOU TAKING ANY MEDICATIONS,** PILLS, DRUGS, NON-PRESCRIPTION, HOMEOPATHIC OR "NATURAL" REMEDIES, INCLUDING DIET PILLS, VIAGRA, ETC.? Y N
     PLEASE LIST:
     _____
     _____
     _____
9. ARE YOU ALLERGIC OR HAD BAD 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. FOOD ALLERGIES (EGGS, DAIRY) ETC? Y N
   - H. OTHER ALLERGIES OR REACTIONS? Y N
     IF YES, PLEASE LIST: _____
     _____
10. DO YOU SMOKE OR CHEW TOBACCO? Y N
    HOW MUCH DAILY? _____
11. DO YOU USE ALCOHOL? Y N
    HOW MUCH? _____
12. HAVE YOU EVER SOUGHT PROFESSIONAL CARE FOR DRUG ABUSE, ALCOHOLISM OR EMOTIONAL DISORDERS? 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. DO YOU WISH TO TALK WITH THE DOCTOR PRIVATELY ABOUT ANYTHING? Y N
15. **WOMEN:**
    - A. ARE YOU TAKING HORMONE REPLACEMENTS? Y N
    - B. ARE YOU PREGNANT OR PLANNING PREGNANCY? Y N
    - C. ARE YOU NURSING? Y N
    - D. ARE YOU TAKING BIRTH CONTROL PILLS? Y N

    IF YOU ARE TAKING BIRTH CONTROL PILLS, THE USE OF ANTIBIOTICS (AND SOME OTHER MEDICATIONS) MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES FOR THAT MONTH'S CYCLE. OTHER METHODS OF BIRTH CONTROL ARE RECOMMENDED.

    DO YOU UNDERSTAND? Y N

X _____ _____

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY — DATE

MEDICAL UPDATE

PATIENT'S SIGNATURE	EXCEPTIONS OR CHANGES	DATE
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SUBMIT