

PATIENT: _____

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

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|---|---|---|--|---|---|
| 1. Are you in good health?..... | Y | N | E. Tranquilizers (Valium)..... | Y | N |
| 2. Has there been any change in your general health in the past year?..... | Y | N | F. Insulin, Diabinese, etc..... | Y | N |
| 3. Date of last physical exam: _____ | | | G. Digitalis, Inderal, Nitroglycerin, Calcium, Channel Blockers, Procardia, or other heart medicine... | Y | N |
| 4. Are you now under a physician's care for a particular problem?..... | Y | N | H. Aspirin or Ibuprofen (Motrin, Naprosyn)..... | Y | N |
| 5. Have you had any serious illnesses, operations or hospitalizations? If so, describe..... | Y | N | I. Marijuana or other "Street Drugs"..... | Y | N |
| 6. Have you had any adverse effects from dental treatment?..... | Y | N | J. Antihistamines or decongestants (Seldane)..... | Y | N |
| | | | K. Pamidronate (Aredia), Zoledronate (Zometa)..... | Y | N |
| | | | Alendronate (Fosamax)?..... | Y | N |

DO YOU HAVE OR HAVE YOU EVER HAD:

- | | | | | | |
|--|---|---|---|---|---|
| A. Rheumatic Fever or Rheumatic Heart Disease..... | Y | N | 8. Are you taking any other regular medications, pills, or drugs?..... | Y | N |
| B. Congenital Heart Disease..... | Y | N | If yes, Please list: _____ | | |
| C. Cardiovascular Disease (Heart Attack, Heart Murmur, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)..... | Y | N | 9. Are you allergic to or have you ever had a reaction to: | | |
| D. Lung Disease (Asthma, Emphysema, Bronchitis, Pneumonia, Tuberculosis, Chest Pain, Shortness of Breath)..... | Y | N | A. Local anesthetic (Novocaine, etc.)..... | Y | N |
| E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Nervous Disorder or Breakdown..... | Y | N | B. Penicillin, Amoxicillin, Cephalosporins or other antibiotics?..... | Y | N |
| F. Bleeding Disorder, Anemia, Transfusion, or Bleed Easily..... | Y | N | C. Barbiturates, Sedatives, etc.?..... | Y | N |
| G. Liver Disease (Jaundice, Hepatitis)..... | Y | N | D. Aspirin or Ibuprofen..... | Y | N |
| H. Kidney Disease..... | Y | N | E. Codeine or other Pain Killers..... | Y | N |
| I. Thyroid disease..... | Y | N | F. Latex or Rubber Products..... | Y | N |
| J. Stomach ulcers or Colitis..... | Y | N | G. Other Allergies or Reactions?..... | Y | N |
| K. Glaucoma... | Y | N | If Yes, Please List _____ | | |
| L. Implants placed anywhere in your body (Heart Valve, Hip, Knee)..... | Y | N | 10. Do you smoke or chew tobacco?..... | Y | N |
| M. Radiation treatment for cancer..... | Y | N | 11. Do you use alcohol frequently?..... | Y | N |
| N. Clicking or popping of jaw joint, pain near the ear, difficulty opening mouth, grind or clench teeth | Y | N | 12. Do you have any other condition or problem not listed that you think the doctor should know about?..... | 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 |

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