

TODAY'S DATE _____

NAME _____ ADDRESS _____

DOB _____ HT. _____ WT. _____ OCCUPATION _____

HOME PHONE _____ BUS. PHONE _____ FAX# _____

E-MAIL _____ MARITAL STATUS _____ SS# _____

CLOSEST RELATIVE _____ PHONE NO. _____

If you are completing this form for another person, what is your relationship _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records and will be considered confidential.

- 1. Are you in good health? YES NO
- 2. Any change in general health in the past year? YES NO
- 3. My last physical was on _____
- 4. Are you now under the care of a physician? YES NO
- 5. The name and address of my physician is: _____

- 6. Have you had a serious illness in the past 5 years? YES NO
If so what is the problem? _____

- 7. Do you have or have you had, any of the following conditions?

- Rheumatic fever or rheumatic heart disease YES NO
- Congenital heart lesions YES NO
- Mitral valve prolapse YES NO
- Cardiovascular disease (heart trouble, heart attack, high blood pressure, arteriosclerosis stroke) YES NO
- Do you have pain in your chest upon exertion? YES NO
- Are you short of breath after mild exercise? YES NO
- Do your ankles swell? YES NO
- Do you have a cardiac pacemaker? YES NO
- Do you have a latex allergy? YES NO
- Other allergies _____
- Sinus trouble? YES NO
- Asthma or Hay Fever? YES NO
- Do you have any orthopedic replacements i.e., hip, knee, etc? YES NO
- Hives or Skin Rash? YES NO
- Fainting Spells or Seizures? YES NO

Diabetes?	YES	NO
Do you pass water more than 6 times a day?	YES	NO
Are you thirsty much of the time?	YES	NO
Is your mouth consistently dry?	YES	NO
Hepatitis, Jaundice or Liver Disease?	YES	NO
Arthritis	YES	NO
Inflammatory Rheumatism (swollen joints)	YES	NO
Stomach Ulcers	YES	NO
Kidney troubles	YES	NO
Tuberculosis	YES	NO
Do you have a persistent cough or cough blood?	YES	NO
Low Blood Pressure	YES	NO
Venereal Disease	YES	NO
Have you had any abnormal bleeding associated with extractions, surgery or trauma?	YES	NO
Do you have any blood disorder such as anemia?	YES	NO
Have you had any surgery or xray treatment for a tumor, growth, or other condition of your head or neck?	YES	NO
Are you taking any drugs or medication?	YES	NO
If so what? _____		
Are you taking any of the following:		
Antibiotics or sulfa drugs	YES	NO
Anticoagulants (blood thinners)	YES	NO
High blood pressure medication	YES	NO
Steroids (i.e. cortisone)	YES	NO
Tranquilizers	YES	NO
Antihistamines	YES	NO
Aspirin	YES	NO
Insulin or similar drug	YES	NO
Digitalis or heart trouble medication	YES	NO
Nitroglycerin	YES	NO
Oral contraceptive or other hormonal therapy	YES	NO
Other _____		
Are you allergic to or have you reacted adversely to:		
Local anesthetic	YES	NO
Penicillin or other antibiotics	YES	NO
Sulfa drugs	YES	NO
Barbituates, sedative or sleeping pills	YES	NO
Aspirin	YES	NO
Codeine or other narcotics	YES	NO
Other _____		
Have you had any serious trouble associated with any previous dental treatment?	YES	NO
If so explain _____		
Are you employed in any situation which exposes you regularly to xray radiation?	YES	NO

WOMEN, are you pregnant? If so, how many months? _____

Whom may we thank for referring you _____

Signature of patient _____