HEALTH HISTORY

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

DO YOU HAVE OR HAVE YOU EVER HAD:

Rheumatic Fever or Rheumatic Heart Disease.....	Y	N
Congenital Heart Disease.....	Y	N
High Blood Pressure.....	Y	N
Mitral Valve Prolapse.....	Y	N
Asthma.....	Y	N
Seizures, Convulsions, Epilepsy, Fainting.....	Y	N
Bruise Easily, Bleeding Disorder.....	Y	N
Hepatitis.....	Y	N
Kidney Disease.....	Y	N
Diabetes.....	Y	N
Thyroid Disease.....	Y	N
Arthritis.....	Y	N
Stomach Ulcers or Colitis.....	Y	N
AIDS/HIV Positive.....	Y	N
Implants placed anywhere in your body		
(Heart Valve, Hip, Knee, Pacemaker).....	Y	N
Radiation Treatment for Cancer.....	Y	N
Grind or Clench Teeth, Clicking/Popping Jaw Joint..	Y	N
Sinus or Nasal Problems.....	Y	N
Any disease, drug, or transplant operation that		
has depressed your immune system.....	Y	N
Are you pregnant or **is there a chance** that you are?	Y	N
Are you taking birth control pills?.....	Y	N

All responses are kept confidential

Do you smoke or chew tobacco?.....	Y	N
Past History of Alcohol or Chemical Dependency?	Y	N
Emotional Disorder that may affect the care that		
we provide?	Y	N
Do you require antibiotics before dental treatment?	Y	N

Are you using any of the following: (Circle)

Antibiotics, Anticoagulants, Aspirin, Motrin, Aleve, Ibuprofen, High Blood Pressure Medication, Steroids (Cortisone, etc), Tranquilizers, Insulin, Oral Anti-Diabetic Drugs, Digitalis, Inderal, Nitroglycerin or other Heart Drugs

Are you taking or have you ever taken

Fosamax or Actonel for Oseoporosis.....	Y	N
Chemotherapy for multiple myeloma, etc	Y	N
Have you ever taken Fen-Phen/Redux?	Y	N

Please list all medications you are currently taking including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or mineral supplements:_____

_____

_____

List Any allergies:_____

_____

_____

I Certify that the answers given are correct to the best of my knowledge

_____ _____

Please Print Name of Patient Patient Signature

_____ _____

Name of Person Authorized to Sign for Patient Signature of Person Authorized to Sign for Patient

_____

Date