Patient's Name _____

Last First Initial Date of Birth

1. Physician's Name _____
   Address _____
2. Are you under a physician's care? ..... YES NO
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? ..... YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? ..... YES NO
6. Are you allergic to any medications or substances? ..... YES NO
7. Do you have any other allergies? ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Do you use any birth control medications? ..... YES NO
12. Have you ever been treated for or been told you might have heart disease? ..... YES NO
13. Do you have a pacemaker or an artificial heart valve implant? ..... YES NO
14. Have you ever had rheumatic fever? ..... YES NO
15. Are you aware of any heart murmurs? ..... YES NO
16. Do you have high or low blood pressure? ..... YES NO
17. Have you ever had a serious illness or major surgery? ..... YES NO

    If so, explain _____
18. Is there any history of cancer in your family? ..... YES NO

    If yes, relationship and type? _____
19. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... YES NO
20. Have you had irregular PAP smears in the past? ..... YES NO
21. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
22. Do you have any artificial joints/prosthesis? ..... YES NO
23. Do you have any blood disorders, such as anemia, leukemia, etc.? ..... YES NO
24. Have you ever bled excessively after being cut or injured? ..... YES NO
25. Do you have any stomach problems? ..... YES NO
26. Do you have any kidney problems? ..... YES NO
27. Do you have any liver problems? ..... YES NO
28. Are you diabetic? ..... YES NO
29. Do you have asthma? ..... YES NO
30. Do you have epilepsy or seizure disorders? ..... YES NO
31. Have you ever been diagnosed with sleep apnea? ..... YES NO
32. Do you or have you used a CPAP machine? ..... YES NO
33. Do you or have you had venereal disease? ..... YES NO
34. Have you tested HIV positive? ..... YES NO
35. Do you have AIDS? ..... YES NO
36. Have you had or do you test positive for hepatitis? ..... YES NO
37. Do you have or have you had T.B.? ..... YES NO
38. Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
39. Do you consume alcoholic beverages? ..... YES NO
40. Do you habitually use controlled substances? ..... YES NO
41. Have you had psychiatric treatment? ..... YES NO
42. Do you have any disease, condition, or problem not listed? If so, explain _____

    _____
43. Is there anything else we should know about your health that we have not covered on this form?

    _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

2. _____ DATE _____ 3. _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

MEDICAL HISTORY