MEDICAL HISTORY

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

*For the following questions, please mark **Yes** or **No**. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.*

Are you currently in good health? □Yes □No

In the last year, have there been any changes in your general health? □Yes □No

My last physical examination was on: _____(mm/yyyy)

Are you currently under the care of a physician? □Yes □No

If so, what is the condition that you are being treated for?

_____

Name of Physician:_____

Have you had any serious illness or hospitalizations in the last 5 years? □Yes □No

If yes, please describe:

_____

Do you or have you had any of the following diseases or complications?

Do you ever have chest pain while doing activities? □Yes □No
Do you ever have shortness of breath while doing exercise? □Yes □No
Have you ever had problems with swollen ankles? □Yes □No
Have you ever had congenital heart defects? □Yes □No
Do you have a pacemaker? □Yes □No
Have you ever had bleeding problems? □Yes □No
Have you ever required a blood transfusion? □Yes □No
Have you ever had a blood disorder (anemia, etc)? □Yes □No
Have you had damaged or artificial heart values or heart disease? □Yes □No
Have you had cardiovascular disease? □Yes □No

Allergies	□Yes	□No
Asthma	□Yes	□No
AIDS/HIV	□Yes	□No
Thyroid Problems	□Yes	□No
Respiratory Problems	□Yes	□No
Kidney Trouble	□Yes	□No
Chronic cough	□Yes	□No
Coughing up blood	□Yes	□No
Low Blood Sugar	□Yes	□No
Epilepsy or Neurological Problems	□Yes	□No
Cancer	□Yes	□No
Sinus Trouble	□Yes	□No
Fainting Spells	□Yes	□No
Diabetes	□Yes	□No
Hepatitis/Jaundice/Liver Problems	□Yes	□No
Stomach Problems	□Yes	□No
Tuberculosis	□Yes	□No
Sexually Transmitted Disease	□Yes	□No
Mental Health Problem	□Yes	□No
Immune System Problems	□Yes	□No

Do you have any allergies to:

Anesthesia	□Yes	□No
Sulfa Drugs	□Yes	□No
Narcotics	□Yes	□No
Penicillin or Antibiotics	□Yes	□No
Barbiturates	□Yes	□No
Iodine	□Yes	□No
Other	□Yes	□No

If there are others, please describe:_____

_____

Have you ever had problems with previous dental treatment? □Yes □No

If yes, please describe:_____

_____

Do you wear contact lenses? □Yes □No Do you wear dentures? □Yes □No

Women Only:

Are you pregnant?	□Yes	□No
Are you on birth control?	□Yes	□No