HEALTH INFORMATION

Reason for today's visit: _____

Are you experiencing any pain? ☐ Yes ☐ No

Have you ever been HOSPITALIZED? ☐ Yes ☐ No *If so, for what?* _____

Have you ever had any of the following? Please choose Yes or No for each question:

☐ Yes	☐ No	Rhuematic fever / Rheumatic Heart disease	☐ Yes	☐ No	Radiation Treatment
☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Kidney Trouble
☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Liver Problems or Hepatitis
☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No	Addison's Disease
☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Thyroid Trouble or Goiter
☐ Yes	☐ No	Angina or Chest pain on exertion	☐ Yes	☐ No	Epilepsy or seizures
☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Convulsions
☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Problems with the immune system
☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Stomach Ulcers
☐ Yes	☐ No	Bronchial Asthma	☐ Yes	☐ No	Arthritis
☐ Yes	☐ No	Hay Fever, Hives, or Skin Rash	☐ Yes	☐ No	Glaucoma or Cataracts
☐ Yes	☐ No	Diabetes or Hypoglycemia	☐ Yes	☐ No	Thrombophlebitis or Blood Clothes
☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Knee or Hip Replacements
☐ Yes	☐ No	Cancer or Leukemia	☐ Yes	☐ No	Porphyria
☐ Yes	☐ No	Anesthesia complications	☐ Yes	☐ No	Mental Illness
☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Osteoporosis

Have you ever had abnormal bleeding associated with previous extractions or surgery? ☐ Yes ☐ No

Are you taking any of the following drugs? *(check Yes or No)*

☐ Yes	☐ No	Antibiotics or sulfa drugs	☐ Yes	☐ No	Insulin, tolbutamide (orinase or such)
☐ Yes	☐ No	Coumadin / Plavix (blood thinners)	☐ Yes	☐ No	Digital or drugs for heart trouble
☐ Yes	☐ No	Drugs for High Blood Pressure	☐ Yes	☐ No	Nitroglycerine
☐ Yes	☐ No	Cortisone (Steroids)	☐ Yes	☐ No	Barbiturates
☐ Yes	☐ No	Tranquilizers	☐ Yes	☐ No	Biphosphonates (fosomax)

Please list any medications you are taking: _____

_____

Have you ever taken the appetite suppressant Fen-Phen? ☐ Yes ☐ No

Are you Allergic to any of the following?

☐ Yes	☐ No	Local Anesthetics	☐ Yes	☐ No	Aspirin
☐ Yes	☐ No	Penicillin or Antibiotics	☐ Yes	☐ No	Iodine
☐ Yes	☐ No	SulfaDrugs	☐ Yes	☐ No	Codeine
☐ Yes	☐ No	Barbiturates, Sedatives, sleeping pills	☐ Yes	☐ No	Latex
Eggs:	☐ Yes ☐ No	**Soy:** ☐ Yes ☐ No	**Other:**		_____

1. Have you ever had any problems associated with previous dental treatments? ☐ Yes ☐ No
2. Are you wearing contact lenses? ☐ Yes ☐ No
3. Do you smoke? ☐ Yes ☐ No *If so, how much?* _____
4. Are you taking or have you ever taken any of the following?
   Marijuana ☐ Yes ☐ No | **Heroin** ☐ Yes ☐ No | **LSD or PSP** ☐ Yes ☐ No | **Methadone** ☐ Yes ☐ No
   Other Uppers or downers ☐ Yes ☐ No *If so, what kind?* _____
5. Do you consider yourself a nervous or tense person? ☐ Yes ☐ No
6. Do you have any disease, condition, or problem not listed? ☐ Yes ☐ No *If yes, what?* _____

Height _____ Weight _____

Do you have a history of TMJ (Jaw Joints) problems? ☐ Yes ☐ No

Do you have or have your ever had any trouble opening your mouth wide? ☐ Yes ☐ No

Have you ever had an injury to the face, jaw, or neck? ☐ Yes ☐ No Does your jaw pop or click? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Signature of Patient (Parent or Guardian if minor) _____ Date_____