PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N) ALL RESPONSES ARE KEPT CONFIDENTIAL

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam? _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you had any serious illnesses, operations or hospitalizations? If so, describe:

   _____

   _____
6. Have you had any adverse effects from dental treatment? ..... Y N

   If so, describe: _____

   _____
7. Do you have or have you ever had:
   - A. Rheumatic fever or rheumatic heart disease? ..... Y N
   - B. Congenital heart disease? ..... Y N
   - C. Cardiovascular disease? ..... Y N
     1. Heart attack ..... Y N
     2. Heart murmur ..... Y N
     3. Coronary artery disease ..... Y N
     4. Angina, chest pain ..... Y N
     5. High blood pressure ..... Y N
     6. Palpitations ..... Y N
     7. Heart surgery ..... Y N
     8. Pacemaker ..... Y N
   - D. Lung disease?
     1. Asthma ..... Y N
     2. Emphysema ..... Y N
     3. Chronic or severe cough ..... Y N
     4. Bronchitis ..... Y N
     5. Pneumonia ..... Y N
     6. Tuberculosis ..... Y N
     7. Shortness of breath ..... Y N
   - E. Neurological disease?
     1. Seizures or convulsions ..... Y N
     2. Epilepsy ..... Y N
     3. Fainting ..... Y N
     4. Dizziness ..... Y N
     5. Nervous disorder or breakdown ..... Y N
     6. Psychiatric treatment ..... Y N
   - F. Bleeding disorder?
     1. Anemia ..... Y N
     2. Bleeding tendency ..... Y N
     3. Blood transfusion ..... Y N
     4. Bruise easily ..... Y N
   - G. Liver disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach ulcers or colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Frequent or recurring mouth sores? ..... Y N
   - O. Implants placed anywhere in your body (heart valve, hip, knee)? ..... Y N
   - P. Radiation (x-ray) treatment for cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .... Y N
   - R. Sinus or nasal problems? ..... Y N
   - S. Any disease, drugs or transplant operation that has depressed your immune system? ..... Y N
   - T. Recurrent infections of any kind? ..... Y N
   - U. Excessive weight loss? ..... Y N
   - V. Hypoglycemia? ..... Y N
   - W. Malignancies? ..... Y N
   - X. Night Sweats? ..... Y N
   - Y. Venereal disease? ..... Y N
8. Are you using or taking any of the following:
   - A. Antacids or other stomach medications? ..... Y N
     If yes, list: _____
   - B. Thyroid medications? ..... Y N
   - C. Antibiotics or sulfa drugs? ..... Y N
   - D. Anticoagulants (blood thinners)? ..... Y N
   - E. High blood pressure medicine? ..... Y N
   - F. Steroids (Cortisone, etc.)? ..... Y N
   - G. Tranquilizers (Valium, etc.)? ..... Y N
   - H. Insulin, Diabenese, or similar drug? ..... Y N
   - I. Digitalis, Inderal, nitroglycerin, calcium channel blockers, Procardia or other heart medicine? ..... Y N
     If yes, list: _____
   - J. Aspirin or ibuprofen (Motrin, Naprosyn, etc.)? ..... Y N
     How much daily? _____
   - K. Marijuana or other "street" drugs? ..... Y N
   - L. Antihistamines or decongestants (Seldane)? ..... Y N
   - M. Are you taking any other regular medications, pills, or drugs? ..... Y N
     If yes, please list: _____
9. Are you allergic or have you had a bad reaction to:
   - A. Local anesthetic (Novocaine, etc.)? ..... Y N
   - B. Penicillin, Amoxicillin, Cephalosporins or other antibiotics? ..... Y N
   - C. Barbiturates, sedatives, etc.? ..... Y N
   - D. Aspirin or ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or rubber products? ..... Y N
   - G. Other allergies or reactions? ..... Y N
     If yes, please list: _____

     _____
10. Do you smoke or chew tobacco? ..... Y N

    How much daily? _____
11. Do you use alcohol? ..... Y N

    How much? _____
12. Have you ever sought professional care for drug abuse, alcoholism or emotional disorders? ..... Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
14. Do you wish to talk to the doctor privately about anything? ..... Y N
15. **WOMEN** Are you pregnant or planning pregnancy? ... Y N
    Are you taking birth control pills? ..... Y N
    Are you taking hormone replacements? ..... Y N
    Are you breastfeeding? ..... Y N

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor. In signing this agreement, I certify that the facts stated are correct.

Signature _____ Date _____ RN/Doctor's Initials _____