Name_____ Date of Birth_____ Date_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and are 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.

1. Are you in good health? .....Y N

2. Has there been any change in your general health within the past year? .....Y N

3. My last physical examination was on _____.

4. Are you under the care of a physician? .....Y N
   a) If, so what is the condition being treated?_____.
   b) The name and address of my Physician(s) is/are:
   _____
   _____
   _____

5. Have you had any serious illness, operation, or been hospitalized in the past 5 years? .....Y N

6. Are you taking any medicine(s) including nonprescription medicines? .....Y N
   a) If, so what medicine(s) are you taking? _____
   _____
   _____

7. Do you have or have you had any of the following diseases or Problems?
   a) Rheumatic fever .....Y N
   b) Scarlet fever .....Y N
   c) Heart trouble/attack.....Y N
   d) Heart murmur .....Y N
   e) High blood pressure .....Y N
   f) Stroke. palpitations .....Y N
   g) Asthma, emphysema ..Y N
   h) Chronic cough, bronchitis pneumonic, tuberculosis, shortness of breath .....Y N
   i) Chest pains .....Y N
   j) Seizures, convulsions ...Y N
   k) Epilepsy, fainting.....Y N
   l) Nervous disorder .....Y N
   m) AIDS or HIV .....Y N
   n) Hepatitis, Jaundice or liver disease .....Y N
   o) Diabetes .....Y N
   p Persistent diarrhea or recent weight loss ....Y N
   q) Thyroid problems .....Y N
   r) Arthritis or painful swollen joints .....Y N
   s) Stomach ulcer or hyperacidity .....Y N
   t) Kidney trouble .....Y N
   u) Low blood pressure ....Y N
   v) Sexually transmitted disease .....Y N
   w) Cancer .....Y N
   x) Problems with mental health .....Y N
   y) Blood transfusion .....Y N
   z Blood disorder .....Y N

8. Are you allergic or have you had a reaction to:
   a) Local Anesthetics .....Y N
   b) Penicillin or other antibiotics.....Y N
   Name_____
   c) Barbiturates, sedatives, or sleeping pills .....Y N
   Name_____
   d) Sulfa Drugs .....Y N
   e) Aspirin .....Y N
   f) Iodine .....Y N
   g) Codeine or other narcotics .....Y N
   Name _____
   h) other _____

9. Have you had any serious trouble with any previous dental treatment? .....Y N
   a) If, so explain_____
   _____
   _____

10. Do you have any disease, condition or problem not listed above that we need to know? .....Y N
    a) If, so explain_____
    _____
    _____

11. Are you wearing contact lenses? .....Y N

12. Are you wearing removable dental appliances? .....Y N

WOMEN

1. Are you pregnant? .....Y N

2. Do you have any problems associated with your menstrual period? .....Y N

3. Are you taking birth control pills? .....Y N

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of patient

Office use Only

Date **Comments**

_____
_____
_____
_____
_____