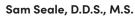


Health History

01. Are you having pain or discomfort at this time?					NO
02. Do you feel nervous about having dental treatment?				YES	NO
03. Have you ever had a bad experience in the dental office?				YES	NO
04. Have you been hospitalized during the past two years?				YES YES	NO
05. Have you been under the care of a physician during the past two years?					NO
Physician's Name					
Address Phone #					
Address			Frione #		
06. Are you now taking any medication, drugs or pills?					NO
If yes, please list:					
07. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?				YES	NO
If yes, please list:					
08. If you smoke, please list ho	w many	packs	_ per day, and for years.		
09. Do you use other tobacco	product	s? (Snuff. ch	newina tobacco. etc.)	YES	NO
, ,					
10. Indicate which of the follow	ving you	nave naa d	or nave at the present:		
Heart Failure	YES	NO	Emphysema	YES	NO
Heart Disease/Attack	YES	NO	Cough	YES	NO
Angina Pectoris	YES	NO	Tuberculosis	YES	NO
Heart Murmur	YES	NO	Asthma	YES	NO
Rheumatic Fever	YES	NO	Hay Fever/Allergies	YES	NO
Scarlet Fever	YES	NO	Artificial Heart Valve	YES	NO
Thyroid Disease	YES	NO	Heart Pacemaker	YES	NO
Artificial Joints (Hip, Knee)	YES	NO	Diabetes	YES	NO
Anemia	YES	NO	Chemotherapy	YES	NO
Stroke	YES	NO	Arthritis	YES	NO
Kidney Trouble	YES	NO	Cortisone Medication	YES	NO
Ulcers	YES	NO	Glaucoma	YES	NO
Cosmetic Surgery(any type)	YES	NO	Pain in jaw joints	YES	NO
High Blood Pressure	YES	NO	Hepatitis A or B	YES	NO
Liver Disease	YES	NO	Drug Addiction	YES	NO
Blood Transfusion	YES	NO	Sexually Transmitted Diseases	YES	NO
Hemophilia	YES	NO	Epilepsy/Seizures	YES	NO
Fever Blisters	YES	NO	Leukemia	YES	NO
Fainting/Dizzy Spells	YES	NO	Bruise Easily	YES	NO
AIDS/HIV	YES	NO		YES	NO
11. Do you tire easily, have pain in your chest, or shortness of breath when climbing stairs or walking short distances?					NO







12. Do your ankles swell during the day?	YES	NO
13. Do you use more than 2 pillows to sleep?	YES	NO
14. Have you lost or gained more than 10 pounds in the past year?	YES	NO
15. Do you wake up from sleep short of breath?	YES	NO
16. Are you on a special diet?	YES	NO
17. Has your physician ever diagnosed you with cancer or a tumor?	YES	NO
18. Do you have any condition not listed?	YES	NO
19. Do you have any Immuno suppressive diseases?	YES	NO
For Women Only		
Are you pregnant? YES NO If yes, what month are you in?		
Are you taking birth control pills: YES NO		
I understand the above information is necessary to provide me with dental care in a safe manner. I have answered all questions truthfully and to the best of my knowledge.	and effic	ient
Patient Signature Date		
i dieni dignarare Date		