

## 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 answer each with yes or no:**

Rheumatic fever/Rheumatic Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Problems or Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Addison's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Trouble or Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina or Chest pain on exertion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with the Immune System	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchial Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever, Hives or Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma or cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes or Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thrombophlebitis or Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Knee or Hip Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer or Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Porphyria	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anesthesia complications	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No

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)**

Antibiotics or sulfa drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin, tolbutamide (orinase or such)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coumadin/Plavix(blood thinners)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Digitalis or drugs for heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drugs for high blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nitroglycerine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone (Steroids)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Barbiturates	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tranquilizers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Biphosphonates(fosomax)	<input type="checkbox"/> Yes <input type="checkbox"/> No

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?**

Local Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin or antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Iodine	<input type="checkbox"/> Yes <input type="checkbox"/> No
SulfaDrugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Barbiturates, sedatives, sleeping pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eggs <input type="checkbox"/> Yes <input type="checkbox"/> No	Soy <input type="checkbox"/> Yes <input type="checkbox"/> 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 yes, how much? \_\_\_\_\_

4. Are you taking or have you ever taken any of the following:

Marijuana  Yes  No Heroin  Yes  No LSD or PCP  Yes  No Methadone  Yes  No  
Other uppers or downers  Yes  No

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? \_\_\_\_\_

Do you have or have you ever had any trouble opening your mouth wide? \_\_\_\_\_

Have you ever had an injury to the face, jaw, or neck? \_\_\_\_\_ Does your jaw pop or click? \_\_\_\_\_

**Women:** Are you pregnant? \_\_\_\_\_ Are you taking birth control pills? \_\_\_\_\_

Signature of Patient (Parent or Guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_