

MEDICAL INFORMATION

Yes No

- Are you in good health?
 Has there been any change in your general health within the past year? Explain _____
 Are you now under the care of a physician? If so, what is/are the condition(s) being treated: _____

Date of your last physical exam: _____ Your physician's name(s): _____

- Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so what was the illness or medical problem: _____
 Are you taking, or have recently taken any medicine(s) including non-prescription medication? *Please list those medicines:*

(WOMEN ONLY)	Yes No	Yes No	Yes No
	<input type="checkbox"/> <input type="checkbox"/> Pregnant or could be?	<input type="checkbox"/> <input type="checkbox"/> Birth Control Pills ?	<input type="checkbox"/> <input type="checkbox"/> Hormone Replacement (HRT)?
	<input type="checkbox"/> <input type="checkbox"/> Are you nursing?	<input type="checkbox"/> <input type="checkbox"/> Ever taken bisphosphonates (ie. Fosamax, Actonel, Boniva, etc.)	

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

- | | | |
|--|--|---|
| <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> AIDS or HIV infection</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Transfusion
<i>If yes, date</i> _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Chemotherapy or Radiation</p> <p><input type="checkbox"/> <input type="checkbox"/> Cardiovascular Disease
<i>If yes, check all that apply:</i></p> <p style="margin-left: 20px;"><input type="checkbox"/> Angina</p> <p style="margin-left: 20px;"><input type="checkbox"/> Arteriosclerosis</p> <p style="margin-left: 20px;"><input type="checkbox"/> Artificial Heart Valve</p> <p style="margin-left: 20px;"><input type="checkbox"/> Coronary Insufficiency</p> <p style="margin-left: 20px;"><input type="checkbox"/> Coronary Occlusion</p> <p style="margin-left: 20px;"><input type="checkbox"/> Damaged Heart Valve</p> <p style="margin-left: 20px;"><input type="checkbox"/> Heart Attack</p> <p style="margin-left: 20px;"><input type="checkbox"/> Heart Murmur</p> <p style="margin-left: 20px;"><input type="checkbox"/> High Blood Pressure</p> <p style="margin-left: 20px;"><input type="checkbox"/> Inborn Heart Defect</p> <p style="margin-left: 20px;"><input type="checkbox"/> Mitral Valve Prolapse</p> <p style="margin-left: 20px;"><input type="checkbox"/> Pacemaker</p> <p style="margin-left: 20px;"><input type="checkbox"/> Rheumatic Heart Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain upon exertion</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Persistent diarrhea</p> | <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Immunosuppressed</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p style="margin-left: 20px;"><input type="checkbox"/> Type I (Insulin dependent)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Type II</p> <p><input type="checkbox"/> <input type="checkbox"/> Dry Mouth</p> <p><input type="checkbox"/> <input type="checkbox"/> Eating Disorder
<i>If yes, specify</i> _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> G.I. gastric reflux</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis, jaundice, liver disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Recurrent Infections
<i>if yes, please specify:</i>
_____</p> <p><input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental Health Disorders
<i>specify:</i> _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug / Alcohol dependence</p> <p><input type="checkbox"/> <input type="checkbox"/> Prosthetic joint
<i>If yes, please specify which joint and date of surgery</i>
_____</p> <p><input type="checkbox"/> <input type="checkbox"/> Malnutrition</p> <p><input type="checkbox"/> <input type="checkbox"/> Migraine headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Night Sweats</p> | <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Neurological disorders
<i>specify:</i> _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Osteoporosis / Osteopenia</p> <p><input type="checkbox"/> <input type="checkbox"/> Persistent swollen glands</p> <p><input type="checkbox"/> <input type="checkbox"/> Respiratory problems</p> <p style="margin-left: 20px;"><input type="checkbox"/> Emphysema</p> <p style="margin-left: 20px;"><input type="checkbox"/> Bronchitis</p> <p style="margin-left: 20px;"><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Severe headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Severe weight change</p> <p><input type="checkbox"/> <input type="checkbox"/> Sexually transmitted disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> Sores or ulcers in mouth</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Systemic Lupus Eryth.</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have any disease, condition, or problem that we should know about?

<i>Explain:</i> _____

 _____</p> |
|--|--|---|

Are you ALLERGIC, or had a REACTION to:

- | | | |
|---|--|---|
| <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Local anesthetics (Novocaine)</p> <p><input type="checkbox"/> <input type="checkbox"/> Aspirin</p> <p><input type="checkbox"/> <input type="checkbox"/> Foods: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Metals: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other : _____</p> | <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Penicillin</p> <p><input type="checkbox"/> <input type="checkbox"/> Sulfa drugs / Sulfonamides</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Antibiotics _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Preservatives / Additives</p> <p><i>If "yes" to any allergy, explain type of reaction:</i> _____</p> | <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Iodine</p> <p><input type="checkbox"/> <input type="checkbox"/> Codeine / Narcotics</p> <p><input type="checkbox"/> <input type="checkbox"/> Latex</p> <p><input type="checkbox"/> <input type="checkbox"/> Hay fever / Seasonal</p> |
|---|--|---|

Additionally, I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dentist or dental entity

Date	Signature of Patient (Guardian)	comments	office use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____