

Name: _____ Height: _____ Weight: _____

Please circle Yes or No

1. Has there been any change in your health within the last year Yes No
If yes please explain: _____
2. Are you now under the care of a physician Yes No
3. Have you had any serious illness or operation Yes No
4. Have you been hospitalized in the past 5 years Yes No
If yes please explain: _____
5. Do you have, or have you had heart problems? **(Please circle which of the following apply.)**
 - a) Heart murmur, heart valve defect, congenital heart defect or problems
 - b) Rheumatic fever or rheumatic heart disease Yes No
 - c) Heart valve replacement or heart attack Yes No
 - d) High blood pressure or low blood pressure Yes No
 - e) Do you have a pacemaker Yes No
 - f) Irregular or rapid heart beat Yes No
 - g) Chest pains, swollen ankles, hands, artificial joints, prosthetics Yes No
6. Do you have, or have you had lung problems?
 - a) Asthma, bronchitis, tuberculosis, or emphysema Yes No
7. Do you have, or have you had hepatitis or yellow jaundice, or other liver problems Yes No
8. Do you have, or have you had kidney problems Yes No
9. Do you have, or have you had anemia, bleeding problems, bruise easily Yes No
10. Do you have, or have you had stomach or intestinal problems? Yes No
11. Do you have or have you had endocrine problems?
 - a) Diabetes (high blood sugar), hypoglycemia (low blood sugar) Yes No
12. Do you smoke? Yes No How much per day? _____
13. Do you drink? Yes No How much per day? _____
14. Have you been diagnosed with glaucoma Yes No
15. Do you have fainting spells, seizures, or epilepsy Yes No
16. Have you had, or do you have a serious viral illness Yes No
17. Do you have arthritis, inflammatory rheumatism, or gout Yes No
18. Do you have persistent cough or cough up blood Yes No
19. Have you ever had a stroke Yes No If yes, when? _____
20. Do you have a sexually transmitted disease Yes No If yes, when treated? _____
21. Do you have an auto-immune disorder Yes No
22. Have you had abnormal bleeding/problems with previous teeth removal Yes No
23. Have you had any head, neck, or jaw injuries Yes No
24. Have you experienced any problems in your jaw, such as
 - a) Clicking, pain in the joint, ear, or side of face. Yes No
 - b) Difficulty opening or closing your mouth or chewing Yes No
25. Please circle any of the following drugs you are currently taking: Aspirin Antibiotics Anticoagulants (blood thinners)
Antihistamines Birth control pills Blood pressure medicine Cortisone(steroids) Tranquilizers or sedatives Insulin
Diabetes drugs Antidepressants Thyroid medication Digitalis, Nitroglycerin, or other heart medication
26. List all other medication and herbal supplements that you are currently taking: _____
27. List all medications that you have taken within the past month but are not taking now: _____
28. List all surgeries, x-ray or radiation treatment for a tumor, growth, or other condition: _____
29. Are you allergic to or have a bad reaction to any of the following drugs: (Please Circle)
Local anesthetics Penicillin or other antibiotics Aspirin Barbiturates or sleeping pills Iodine
Sulfa drugs Codeine or other narcotics Steroids Valium, Demerol, or Brevital Pain medication
30. Which pharmacy do you currently use: _____ Telephone# _____
31. Women: Are you or might be pregnant Yes No
When was your last menstrual period? _____
32. If you are having IV Sedation surgery today, have you had anything to eat or drink in the last 8 hours? Yes No

Signature of Patient, Parent or Guardian

Date

Signature of Doctor

Date