

**PLEASE ANSWER ALL QUESTIONS BY CIRCLING Y (yes) or N (no)
ALL RESPONSES WILL REMAIN CONFIDENTIAL**

1. Are you in good health?.....Y N
2. Has there been ANY change in your general health in the past year?.....Y N
If yes, please describe: _____
3. Are you now under a physician's care for a particular problem?.....Y N
If yes, please describe: _____
4. Have you had any serious illnesses, operations or hospitalizations? If yes, describe:.....Y N

5. Do you smoke?.....Y N
6. Do you have or have you ever had:
 - a. Rheumatic fever or rheumatic heart disease?.....Y N
 - b. Congenital heart disease?.....Y N
 - c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, mitral valve)?...Y N
If yes, please describe: _____
 - d. Lung disease (asthma, emphysema, chronic cough, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?.....Y N
If yes, please describe: _____
 - e. Neurological-psychological disorders (convulsions, epilepsy, seizures, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown)?.....Y N
If yes, please describe: _____
 - f. Blood disease (anemia, bleeding tendency, blood transfusion? Do you bruise easily)?.....Y N
If yes, please describe: _____
 - g. Liver disease (jaundice, hepatitis)?.....Y N
 - h. Kidney disease?.....Y N
 - i. Diabetes?.....Y N
 - j. Thyroid disease (goiter)?.....Y N
 - k. Implants placed anywhere in your body (heart, valve, knee, hip, etc.)?.....Y N
 - l. Cancer?.....Y N
7. Do you have:
 - a. Stomach ulcers or colitis?.....Y N
 - b. Sinus or nasal problems?.....Y N
 - c. Any disease, drugs, or transplant operation that has depressed your immune system?.....Y N
 - d. Recurrent infections of any kind?.....Y N
 - e. Problems with anesthesia of any kind?.....Y N
 - f. Sexually transmitted disease?.....Y N
 - g. H.I.V. positive?.....Y N

8. Dental History
 - a. When was your last dental check-up? _____
 - b. Were x-rays taken?.....Y N
 - c. Do your gums bleed?.....Y N
 - d. Do you have sore or sensitive teeth?.....Y N
 - e. Do you have any sores, swelling, or fever blisters in your mouth?.....Y N
 - f. Temporomandibular joint problems?.....Y N
(popping or clicking of jaw joints, pain near ear, difficulty opening mouth, grind or clench teeth).....Y N
 - g. Are you happy with how your teeth look?.....Y N
 - h. Are you happy with the color of your teeth?.....Y N
 - i. What would you change, if anything, about your teeth?

9. Please list ALL MEDICATIONS you are taking: _____

10. Please list all DRUG ALLERGIES: _____

11. Do you have any other disease, condition or problem not listed above that you think the doctor should be made aware of? If yes, please describe:.....Y N

12. Do you wish to talk to the doctor privately about anything?.....Y N
13. Women: Are you pregnant or planning pregnancy?.....Y N
Are you taking birth control pills?.....Y N

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor.

I consent to treatment as necessary or desirable to the care of the patient named, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-rays, or other studies that may be used by the attending doctor or his assistant, or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of service, unless other arrangements are made with the Financial Department.

Signature of Patient, Parent or Agent (Must be 18 yrs or older)

Date

Dr.'s Initials