MEDICAL HISTORY (PLEASE MARK YES OR NO)

1. Has there been a recent change in your health? ---------- No_____ Yes_____
   If yes, please explain_____
2. When was your last physical examination? _____
3. Are you under the care of a physician? ---------- No_____ Yes_____
   If yes, condition: _____
4. Have you been hospitalized or had a serious illness within the last 5 years? ---------- No_____ Yes_____
   If yes, what was the problem?_____
5. Do you have or have you had any of the following? (Please check the appropriate conditions)----------

N	Y	Rheumatic Fever or Heart Problem	N	Y	Diabetes
N	Y	Asthma	N	Y	Fainting Spells or Seizures
N	Y	Tuberculosis	N	Y	Arthritis or Rheumatism
N	Y	Radiation Therapy	N	Y	Heart Murmur
N	Y	High/Low Blood Pressure	N	Y	Kidney Problems
N	Y	Do you have AIDS, A.R.C., or are you HIV positive?	N	Y	Venereal Disease
N	Y	Abnormal Bleeding or Blood Disorders?	N	Y	Are you allergic to metals?
N	Y	Are you allergic to Latex?	N	Y	Liver Disease, Jaundice, Hepatitis A B C D
N	Y	Have you had any joints/organs/body parts artificially replaced or transplanted?			

6. Do you have difficulty breathing through your nose?---------- No_____ Yes_____
7. Are you currently taking any medication?---------- No_____ Yes_____
   If yes, please list:_____
8. Are you allergic to any drugs or medications such as Penicillin, Codeine, or Aspirin?---------- No_____ Yes_____
   If yes, what?_____
9. Do you have any disease, condition, or other problems listed above that you think I should know about?____ No_____ Yes_____
   If yes, what?_____
10. Are you aware of any lumps in your mouth?---------- No_____ Yes_____

Women Only

1. Are you pregnant or is there a chance you could be?---------- No_____ Yes_____
   If so, how many months?_____
2. Are you on any type of birth control?---------- No_____ Yes_____

Dental History

1. Are you aware of any problems at this time?---------- No_____ Yes_____
2. When was your last dental visit?_____
3. What was performed?_____
4. Rate your dental health from 1-10 (1 being poor, 10 being good) 1 2 3 4 5 6 7 8 9 10

Patient/Guardian Signature_____ Date_____ Dr. Signature_____ Date_____

Patient/Guardian Signature_____ Date_____ Dr. Signature_____ Date_____

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