Patient's Name _____ Date: _____

HEALTH INFORMATION

Do you need to Premedicate for your Dental Appointment? YES ( ) NO ( )

ALLERGIES

( ) Aspirin	( ) Codeine	( ) Dental Anesthetics
( ) Erythromycin	( ) Jewelry	( ) Latex
( ) Metals	( ) Penicillin	( ) Sulfa
( ) Tetracycline	( ) Hayfever/Seasonal	( ) Other_____

Have you ever had any of the following? Please check those that apply.

CONDITIONS

( ) Anemia	( ) Diabetes	( ) High Blood Pressure	( ) Rheumatic Fever
( ) Angina Pectoris	( ) Dizziness	( ) HIV/AIDS	( ) Rheumatoid Arthritis
( ) Arthritis	( ) Emphysema	( ) Kidney Disease	( ) Sinus Problems
( ) Artificial Heart Valve	( ) Epilepsy/Seizures	( ) Liver Disease	( ) Stomach Problems
( ) Artificial Joints	( ) Fainting Spells	( ) Low Blood Pressure	( ) Stroke
( ) Asthma	( ) Frequent Headaches	( ) Mental/Nervous Disorders	( ) Thyroid Problems
( ) Blood Thinners	( ) Glaucoma	( ) Mitral Valve Prolapse	( ) Transplants
( ) Blood Transfusion	( ) Head Injuries	( ) Osteoporosis Meds	( ) Tuberculosis
( ) Bruise Easily	( ) Heart Attack	( ) Pacemaker	( ) Ulcers
( ) Cancer	( ) Heart Disease	( ) Pain in Jaw Joints	( ) Other_____
( ) Chemotherapy Treatment	( ) Heart Murmur	( ) Pneumocystis	
( ) Congenital Heart Defect	( ) Heart Surgery	( ) Radiation Therapy	
( ) Dental Complications	( ) Hepatitis	( ) Respiratory Problems	

If Female, are you pregnant? YES ( ) NO ( ) Due Date:_____
Do you use Tobacco products? YES ( ) NO ( )

- Are you now under the care of a physician? ( ) YES ( ) NO
  If yes, please explain:_____
- Do you have any health problems that need further clarification? ( ) YES ( ) NO
  If yes, please explain:_____