

<p>Y N <u>Conditions</u></p> <input type="checkbox"/> <input type="checkbox"/> Heart Murmur <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> <input type="checkbox"/> Heart Attack <input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> <input type="checkbox"/> Allergies <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> <input type="checkbox"/> Bruise Easily <input type="checkbox"/> <input type="checkbox"/> Coumadin Therapy <input type="checkbox"/> <input type="checkbox"/> Cancer Chemotherapy <input type="checkbox"/> <input type="checkbox"/> Colitis <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> <input type="checkbox"/> Drug Abuse <input type="checkbox"/> <input type="checkbox"/> Emphysema	<p>Y N <u>Conditions</u></p> <input type="checkbox"/> <input type="checkbox"/> Epilepsy <input type="checkbox"/> <input type="checkbox"/> Fainting Spells <input type="checkbox"/> <input type="checkbox"/> Fever Blisters <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> HIV AIDS <input type="checkbox"/> <input type="checkbox"/> Heart Surgery <input type="checkbox"/> <input type="checkbox"/> Hemophilia <input type="checkbox"/> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> <input type="checkbox"/> Hepatitis B <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Hip Replacement <input type="checkbox"/> <input type="checkbox"/> Knee Replacement <input type="checkbox"/> <input type="checkbox"/> Kidney Problems <input type="checkbox"/> <input type="checkbox"/> Liver Disease <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Pace Maker <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems <input type="checkbox"/> <input type="checkbox"/> Seizure <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Taken Fen Phen	<p>Y N <u>Conditions</u></p> <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> Ulcers <input type="checkbox"/> <input type="checkbox"/> Venereal Disease <input type="checkbox"/> <input type="checkbox"/> Taken Fosamax or other medications for Osteoporosis <input type="checkbox"/> <input type="checkbox"/> Do you premedicate with antibiotics prior to all dental appointments <p>Y N <u>Allergies</u></p> <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> Codeine <input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics <input type="checkbox"/> <input type="checkbox"/> Erythromycin <input type="checkbox"/> <input type="checkbox"/> Latex <input type="checkbox"/> <input type="checkbox"/> Metals <input type="checkbox"/> <input type="checkbox"/> Penicillin <input type="checkbox"/> <input type="checkbox"/> Tetracycline <p>Other _____</p>
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Do you suffer from Sleep Apnea or do you use a C-PAP machine? Yes _____ No _____

If female, please answer the following:

<p>Y N</p> <input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills? <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If Yes, # if weeks <input style="width: 50px;" type="text"/> <input type="checkbox"/> <input type="checkbox"/> Are you nursing?
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Please answer the following:

<p>Y N</p> <input type="checkbox"/> <input type="checkbox"/> Do you smoke or use tobacco? If yes, how many packs a day _____ How long have you used tobacco? _____

For Office Use:

Pack Yr Hx _____

Medications:

Medical Physician:

Phone # _____

Address _____

Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below....

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)