## card-horizontal-webaddress4

## HEALTH HISTORY

**Do you currently or have you ever had? (Please circle)**

Asthma Yes No Arthritis Yes No

Environmental Allergies Yes No Kidney or Bladder Disease Yes No

Tuberculosis Yes No Hepatitis, Cirrhosis, Liver Disease Yes No

Emphysema Yes No Epilepsy or Seizures Yes No

COPD Yes No Fainting or Dizzy spells Yes No

Angina Yes No Diabetes HgA1C% =\_\_\_\_\_ Yes No

High Blood Pressure \_\_\_\_/\_\_\_\_ Yes No Stomach/Intestinal Ulcers Yes No

Pacemaker Yes No Abnormal Bleeding Yes No

Congenital Heart Defect Yes No HIV positive Yes No

Heart Disease/Attack Yes No Sickle Cell Disease/Trait Yes No

Infective Endocarditis Yes No Radiation Treatment Yes No

Artificial Heart Valve Yes No Chemotherapy Treatment Yes No

Stroke Yes No Alcoholism Yes No

Joint Replacement Yes No Drug addiction Yes No

Thyroid Disease Yes No Smoking/Tobacco Product Use Yes No

Latex Sensitivity Yes No Medications for Osteoporosis Yes No

List all current medications: None List all medical allergies: None

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Are you pregnant or nursing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due Date \_\_\_/\_\_\_/\_\_\_

Any other medical conditions not already noted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL SPECIFIC QUESTIONS: (Please Circle)**

Do you have TMJ (jaw joint) pain? Yes No

OFFICE USE ONLY

ASA I II III IV V

ORTHO Y/N RET Y/N NG Y/N

Do you clinch or grind your teeth? Yes No

Do you currently have pain in your teeth or gums? Yes No

Are you happy with the appearance of your teeth? Yes No

**Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/\_\_\_** Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/\_\_\_

*1) Changes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/\_\_\_**Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/\_\_\_*

*2) Changes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/\_\_\_**Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/*