Patient's Name

ANSWER ALL QUESTIONS by circling Yes (Y) or No (N)

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year? .....Y N
3. Date of last physical exam: _____
4. Are you currently under a physician's care for a specific problem? .....Y N
5. Have you had any serious illnesses, operations or hospitalizations? If so, describe: .....Y N

   _____

   _____
6. Height _____ Weight _____ Sex: M / F

7. **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 Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? .....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?.....Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
   - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
   - H. Kidney Disease?.....Y N
   - I. Diabetes?.....Y N
   - J. Thyroid Disease (Goiter)?.....Y N
   - K. Arthritis?.....Y N
   - L. Stomach Ulcers or Colitis?.....Y N
   - M. Glaucoma?.....Y N
   - N. Osteoporosis .....Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
   - O. Radiation treatment for Cancer? .....Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .....Y N
   - Q. Sinus or Nasal problems?.....Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system (HIV, etc)?.... .....Y N

8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)? .....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - D. High Blood Pressure medications?.....Y N
   - E. Steroids (Cortisone, etc.)? .....Y N
   - F. Tranquilizers .....Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .....Y N
   - H. **Digitalis, Inderal, Nitroglycerin** or other heart medications.....Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonate for osteoporosis, multiple myeloma or other cancers (**Fosamax, Actonel, Boniva, Aredia, Zometa**)? .....Y N
   - J. Please list **any and all medications** taken, including prescription medications, diet drugs, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:_____

     _____

     _____

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .....Y N
   - B. Penicillin or other antibiotics? .....Y N
   - C. Sedatives, Barbiturates?.....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers? .....Y N
   - F. Latex or Rubber Products? .....Y N
   - G. Other allergies or reactions? If yes please list .....Y N

     _____

     _____

10. Do you smoke or chew Tobacco?.....Y N
    How much per day? _____
11. Is there any past history of Alcohol, Chemical Dependency or Emotional Disorder? .....Y N
12. Have you or an immediate family member had any problems associated with intravenous anesthesia?.....Y N
13. Do you have anything not listed that you think the doctor should know about? .....Y N
14. Do you wish to speak privately to the doctor regarding anything? .....Y N

15. **FOR WOMEN ONLY**
    - A. Are you pregnant, or is there any chance you might be pregnant?.....Y N
    - B. Are you nursing?.....Y N
    - C. **If you are using Oral Contraceptives;** it is important you understand that antibiotics (and other medications) may interfere with the effectiveness of your oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

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 Heath History with my doctor.

_____ _____

Date Signature of Patient/Guardian