PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N). ALL RESPONSES ARE KEPT CONFIDENTIAL.

1 ANY ADVERSE EFFECTS FROM DENTAL TREATMENT? Y N

2 DO YOU HAVE JAW POPPING OR PAIN? Y N

3 ARE YOU NOW UNDER A PHYSICIAN'S CARE? Y N

4 DATE OF LAST PHYSICAL EXAM: _____

5 LIST ALL OPERATIONS AND HOSPITALIZATIONS:

DO YOU HAVE OR HAVE YOU HAD:

6 A. SINUS OR NASAL PROBLEMS OR ALLERGIES Y N

B. SLEEP APNEA Y N

C. STROKE, SEIZURE, EPILEPSY Y N

D. MENTAL HANDICAP, PSYCHIATRIC TREATMENT Y N

ALZHEIMER'S OR PARKINSON'S Y N

E. CONGENITAL HEART DISEASE, HEART SURGERY, CHEST PAIN, HEART ATTACK, CONGESTIVE HEART FAILURE, HEART MURMUR, VALVE DISORDER, PALPITATIONS, ARRHYTHMIA, HIGH BLOOD PRESSURE Y N

F. LUNG DISEASE: ASTHMA, COPD, Y N

BRONCHITIS, PNEUMONIA OR TUBERCULOSIS Y N

G. BLEEDING DISORDER OR TENDENCY Y N

OR ANEMIA Y N

H. LIVER DISEASE: JAUNDICE, HEPATITIS Y N

I. KIDNEY DISEASE Y N

J. DIABETES Y N

K. THYROID DISEASE Y N

L. REFLUX OR STOMACH ULCERS Y N

M. COLITIS - ULCERATIVE OR CROHN'S Y N

N. GLAUCOMA Y N

O. ARTHRITIS Y N

P. OSTEOPOROSIS Y N

Q. CANCER Y N

R. RADIATION (X-RAY) TREATMENT FOR CANCER Y N

S. IMPLANTS PLACED ANYWHERE IN YOUR BODY (HEART VALVE /JOINT REPLACEMENT) Y N

T. ANY DISEASE THAT HAS DEPRESSED YOUR IMMUNE SYSTEM OR HIV Y N

U. ANY OTHER DISEASE OR DISORDER NOT LISTED ABOVE, PLEASE LIST:

7 ARE YOU USING OR TAKING ANY OF THE FOLLOWING:

A. ANTIBIOTICS Y N

B. ANTICOAGULANTS (BLOOD THINNERS) Y N

C. HIGH BLOOD PRESSURE OR HEART MEDICINE Y N

D. STEROIDS (CORTISONE) Y N

E. INSULIN OR ORAL MEDICATION FOR DIABETES Y N

F. DRUGS FOR BONES - OSTEOPOROSIS (CURRENTLY USING or USED IN PAST)

Fosamax, Binosto, Actonel, Boniva, Aredia, Reclast, Prolia Y N

DRUGS FOR BONES - CANCER (CURRENTLY USING or USED IN PAST)

Zometa, Xgeva, Avastin, Sutent, Nexavar Y N

G. MARIJUANA OR OTHER "STREET DRUGS" Y N

H. LIST ALL MEDICATIONS YOU TAKE:

8 ARE YOU ALLERGIC OR HAVE YOU HAD A BAD REACTION TO:

A. GENERAL ANESTHESIA OR LOCAL ANESTHETICS Y N

B. PENICILLIN, AMOXICILLIN, CEPHALOSPORIN OR OTHER ANTIBIOTICS Y N

C. ASPIRIN OR IBUPROFEN Y N

D. CODEINE, HYDROCODONE, OR OTHER PAIN MEDICATIONS Y N

E. LATEX Y N

F. EGGS Y N

G. OTHER ALLERGIES OR REACTIONS - PLEASE LIST:

9 DO YOU SMOKE, CHEW, OR DIP TOBACCO Y N

10 DO YOU HAVE OR HAVE YOU HAD AN ALCOHOL OR DRUG DEPENDENCE Y N

11 FOR WOMEN ONLY:

A. If you are using oral contraceptives, it is important that you understand that antibiotics and other medications may interfere with the effectiveness of 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 medications is completed. Please contact your physician for further guidance.

B. If you are pregnant, possibly pregnant or trying to become pregnant, anesthesia and other medications may significantly harm your developing baby, especially during the first trimester.

PLEASE ADVISE YOUR DOCTOR IF THERE IS ANY CHANCE OF YOUR BEING PREGNANT!

C. Are you pregnant? Y N

D. Are you nursing? Y N

I UNDERSTAND THE IMPORTANCE OF AN ACCURATE HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE.

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DATE DOCTOR'S INITIALS