HEALTH INFORMATION

Patient: _____

Date: _____

YES NO Please check the following:

____ ____ 1. Have you been hospitalized within the past two years? For What? _____

____ ____ 2. Are you currently being treated by a physician? For What? _____

____ ____ 3. Are you currently taking any drugs or medicines? What? _____

_____

____ ____ 4. Are you allergic to any drugs? To What?_____

____ ____ 5. Do you have a skin rash or allergy to earrings, rings, wrist watches or nickel?_____

____ ____ 6. Are you allergic to latex rubber?_____

____ ____ 7. Do you take steroids now or in the last twelve months? _____

____ ____ 8. Do you or have you taken any bone building drugs? What type and for how long?_____

____ ____ 9. Do you smoke, dip or chew? Frequency? _____

____ ____ 10. Do you drink alcoholic beverages? Frequency? _____

____ ____ 11. (Females) Are you pregnant? _____

____ ____ 12. Have you ever been treated for chemical dependency? What type? _____

13. Please circle your level of dental anxiety: Low Moderate High

14. Intravenous Sedation is available. Would that interest you? Yes No

Personal Physician_____
Name Address Phone

Pharmacy_____
Name Address Phone

CHECK WHICH OF THE FOLLOWING CONDITIONS HAVE EVER APPLIED TO YOU

____ AIDS
____ Arthritis
____ Asthma
____ Cancer
____ Diabetes
____ Epilepsy
____ Glaucoma
____ Joint Replacement - When? _____

____ Heart Murmur / Valve Replacement
____ Heart Problem
____ Hepatitis (A) (B) (C)
____ High Blood Pressure
____ Kidney Problems
____ Low Blood Pressure
____ Rheumatic Fever

____ Sexually Transmitted Diseases
____ Sickle Cell Disease / Trait
____ Stroke
____ Tuberculosis
____ Ulcers / Stomach Problems
____ Yellow Jaundice
____ Other Diseases / Explain Below:
_____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Address: _____ Phone: _____