HEALTH HISTORY

	YES	NO
1. Have you been under the care of a Medical Doctor during the past two years, or have you been hospitalized in the last two years? If yes, please specify?	☐	☐
Physician: Phone:		
2. When was your last complete physical examination?		
3. Have you recently, or are you presently, taking any **PRESCRIPTION OR NON-PRESCRIPTION** drugs incl. herbal remedies? 1. 2. 3. 4. 5.	☐	☐
4. Have you ever reacted adversely to any of the following? (Please circle.) ANTIBIOTICS - Penicillin, Sulfonamide, other antibiotics, ASPIRIN, BARBITURATES (sleeping pills), CODEINE, DARVON, LOCAL ANAESTHETIC (freezing), NITROUS OXIDE, or been advised against taking any specific type of medication? If so, please list:	☐	☐
5. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions?	☐	☐
6. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain:	☐	☐
7. Has any family member had diabetes?	☐	☐
8. Do you bleed **EXCESSIVELY** from a cut or injury, or bruise easily?	☐	☐
9. Do your ankles, feet or hands swell?	☐	☐
10. Has your weight, appetite or energy level changed dramatically recently, or do you follow a special diet?	☐	☐
11. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
12. Have you tested HIV positive?	☐	☐
13. Do you have **FREQUENT SEVERE** headaches, earaches, ear/throat infections?	☐	☐
14. Have you ever had any injury or surgery to your face, jaws or jaw joints?	☐	☐
15. Do you wear eyeglasses or contact lenses, or have you had any hearing difficulties?	☐	☐
16. Do you smoke, use other forms of tobacco, or are you wearing the transdermal nicotine patch?	☐	☐
17. Are you alcohol and/or drug dependent?	☐	☐
18. Have you been advised to take antibiotics before a dental appointment?	☐	☐
19. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:		
(Please circle.) A.I.D.S. Anemia Angina Pectoris Arthritis/rheumatism Artificial heart valve Artificial joints (hip,knee) Blood disorders Bronchitis Cancer Circulation problems Congenital heart lesions Cortisone/steroid Diabetes Emphysema Epilepsy or seizures Fainting or dizzy spells Glandular disorders Glaucoma Head/neck injuries Heart disease/attack Heart murmur Heart pacemaker Heart rhythm disorder Heart surgery Hepatitis A B C ___ Herpes High/low blood pressure Hodgkins disease Hyper (hypo) Glycemia Hypertension Jaundice Kidney/liver disease Lung disease Malignant Hyperthermia Mental/nervous disorder Mitral valve prolapse Organ transplant/medical implant Psychiatric treatment Radiation treatment/chemotherapy Rheumatic/Scarlet fever Sickle Cell disease Sinus trouble Stomach/intestinal problems Stroke Thyroid disease Tuberculosis Ulcers Venereal disease Other		
20. Has the Child Patient recently had any of the following: (indicate approximate date) Chicken Pox Mumps Measles Strep throat Tonsillitis		
21. Do you currently have, or have you had in the past, any disease, condition or problem not listed?	☐	☐
22. Is there anything else about your health we should be made aware of?	☐	☐
23. Do you wish to speak to the Doctor privately about any problem or medical condition?	☐	☐
24. **WOMEN ONLY:** Are you pregnant or suspect you may be? If yes, what month? Are you taking any birth control pills? Are you breast feeding?		