

MEDICAL HISTORY CONTINUED:

4. Have you ever had an operation? List all _____ 0 Yes 0 No

5. Have you ever been hospitalized for or had a serious illness? List all _____ 0 Yes 0 No

6. Have you ever had any breathing difficulty such as asthma, emphysema, chronic cough, pneumonia, tuberculosis or any other disorder? List all _____ 0 Yes 0 No

7. Do you smoke or use smokeless tobacco? _____ 0 Yes 0 No

8. Do you have or have you had Temporomandibular joint (TMJ) Problems (clicking, popping, or pain)? _____ 0 Yes 0 No

9. Do you have or have you ever had:

Heart trouble/Heart murmur	0 Y	0 N	Positive HIV test	0 Y	0 N
Rheumatic fever	0 Y	0 N	Acquired immune deficiency (AIDS)	0 Y	0 N
Stroke	0 Y	0 N	Asthma / emphysema	0 Y	0 N
High blood pressure	0 Y	0 N	Hepatitis/liver trouble	0 Y	0 N
Diabetes	0 Y	0 N	Implants placed anywhere in your body (heart valve, hip, knee, breast, pacemaker)	0 Y	0 N
Kidney disease	0 Y	0 N	Anemia	0 Y	0 N
Arthritis	0 Y	0 N	Profuse bleeding or easy bruising	0 Y	0 N
Recent cold	0 Y	0 N			

10. Are you using any of the following?

Antibiotics or sulfa drugs	0 Y	0 N	Anticoagulants (blood thinners)	0 Y	0 N
High blood pressure medicine	0 Y	0 N	Steroids (cortisone, etc.)	0 Y	0 N
Insulin or oral diabetic medication	0 Y	0 N	Aspirin	0 Y	0 N
Marijuana, cocaine, or other "street drugs"	0 Y	0 N	Motrin, Ibuprofen, Aleve, or other NSAIDs	0 Y	0 N

11. Are you subject to fainting, nervous disorders, convulsions or epilepsy? _____ 0 Yes 0 No

12: **Women:** 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 during and after the course of antibiotics or other medications is completed. Please consult your physician for further guidance. B. If you are pregnant, possibly pregnant or trying to become pregnant, then surgery, anesthetics or any other medication may harm your developing baby, especially during the first trimester. Please inform the doctor if there is any chance that you might be pregnant.

C. Are you pregnant? 0 Yes 0 No

13. Has there been any change in your general health in the past year? _____ 0 Yes 0 No

14. Are you under the care of a physician for a particular problem? _____ 0 Yes 0 No

15. Your family physician's name is _____ office location (city) _____
date of last physical _____

16. Who referred you to our office? _____

17. What is the reason for seeing the Doctor today? _____

18. Name and number of nearest relative not living with you _____

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE AND CONFIRM THAT IT ADEQUATELY STATES PAST AND PRESENT CONDITIONS.

Signature _____ Date _____