Yes No k. Hepatitis, jaundice or liver disease
Yes No l. Arthritis or inflammatory rheumatism
Yes No m. Artificial or replacement joints, prosthetic
Yes No n. Digestive system - Ulcers or stomach disorders (colitis)
Yes No o. Kidney trouble
Yes No p. Tuberculosis
Yes No q. Persistent cough or cough up blood
Yes No r. Immune System disorders (including AIDS, HIV, ARC)
Yes No s. Venereal Disease
Yes No t. Other: Explain _____

Yes No 7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma
Yes No a. Do you bruise easily
Yes No b. Have you ever required a blood transfusion
If so, explain the circumstances & when _____

Yes No 8. Do you have any blood disorder such as anemia
Yes No 9. Have you had surgery or x-ray treatment for a tumor, growth, or other condition
Yes No 10. Are you taking any of the following (Prescription or over-the-counter):

Yes No a. Antibiotics or sulfa drugs
Yes No b. Anticoagulants (blood thinners)
Yes No c. Medicine for high blood pressure
Yes No d. Cortisone (steroids)
Yes No e. Tranquilizers
Yes No f. Antihistamines
Yes No g. Aspirin
Yes No h. Insulin, tolbutamide or similar drug for diabetes
Yes No I. Digitalis or drugs for heart trouble
Yes No j. nitroglycerin
Yes No k. Fen-Phen, Redux or any other appetite suppressant
Yes No l. Aredia, Zometa, or any other drugs to treat osteoporosis or Paget's disease

Please list medications: _____
_____

11. Are you allergic or have you reacted adversely to:

Yes No a. Local anesthetics
Yes No b. Penicillin or other antibiotics
Yes No c. Sulfa drugs
Yes No d. Barbiturates, sedatives, or sleeping pills
Yes No e. Aspirin
Yes No f. Iodine
Yes No g. Codeine or other narcotics
Yes No h. Latex
Yes No i. Other _____
_____

Yes No 12. Do you use any tobacco products
If so, how much per day and what _____

Yes No 13. Do you use any alcohol products
If so, how much per day/week/month and what _____

Yes No 14. Do you use any caffeinated products (coffee, tea, chocolate, etc.)
If so, how much per day and what _____

Yes No 15. Do you have any disease, condition, or problem not listed above that you think I should know about
_____
_____

Yes No 16. Are you employed in any situation which exposes you to x-rays or other ionizing radiation
Yes No 17. Are you wearing contact lenses
Yes No 18. Are you experiencing stress or pressure in your work or at home

**WOMEN**

Yes No 19. Are you pregnant
Yes No 20. Do you have PMS or problems associated with your menstrual period
Yes No 21. Are you taking birth control or hormone therapy

**Remarks:**

*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medications, I will inform the dentist at the next appointment.*

_____ _____
Signature of Patient Date Signature of Dentist Date