Health Information

Have you ever had or currently have any of the following health conditions?

- Abnornal/Excessive bleeding ______
- AIDS or HIV infection ______
- Alzheimer's/Dementia ______
- Anemia ______
- Anxiety ______
- Asperger ______
- Arthritis ______
- Asthma ______
- Autism ______
- Autoimmune Disease ______
- Bladder ______
- Blood disease ______
- Blood transfusion ______
- Breathing problems/respiratory disease ______
- Bronchitis ______
- Cancer ______
- Cardiovascular disease ______
- Cerebral palsy ______
- Chemotherapy/Radiation treatment ______
- Chest pain ______
- Chronic pain ______
- Cleft lip/ Palate ______
- Congestive heart failure ______
- Convulsions ______
- Damaged heart valves ______
- Developmental delay ______
- Diabetes ______
- Emphysema ______
- Epilepsy ______
- Fainting spells ______
- Gastrointestinal disease ______
- Glaucoma ______
- Gout ______
- Hearing difficulties ______
- Heart attack ______
- Heart murmur ______
- Heart rhythm disorder ______
- Hemophilia ______
- Hepatitis ______
- Hypertension (High Blood Pressure) ______

Joint Replacement ____________________

Kidney Disease ____________________

Liver problems ____________________

Low Blood Pressure ____________________

Lung Disease/COPD ____________________

Measles ____________________

Mouth breathing ____________________

Mumps ____________________

Pacemaker ____________________

Rheumatic Fever ____________________

Rubella ____________________

Seizures ____________________

Speech problems ____________________

Spinal Bifida ____________________

Thumb/Finger sucking ____________________

Thyroid ____________________

Tuberculosis ____________________

Ulcers ____________________

Other, not mentioned ____________________

Any surgeries ____________________

Please explain any conditions you responded "yes" to

Please list any medications (prescription and/or non-prescription) you are currently taking, including contraceptives, herbal supplements, or vitamins

Do you have allergies to any of the following?

Acetaminophen ____________________

Amoxicillin ____________________

Animals ____________________

Aspirin ____________________

Codeine ____________________

Demerol ____________________

Environmental/Seasonal ____________________

Fluoride ____________________

Food ____________________

Ibuprophen ____________________

Iodine ____________________

Latex ____________________

Local Anesthetic ____________

Morphine ____________

Penicillin ____________

Other, not mentioned above ____________

If "yes" to any of the above, please explain

Pregnancy

Were you pregnant in the last 90 days? ____________

Are you currently pregnant? ____________

If "yes" expected due date? ____________

How many weeks along? ____________

Smoking Status

Do you currently smoke? ____________

Are you a former smoker? ____________

Do you have a history or problems with any of the following?

Bleeding Gums ____________

Canker Sores ____________

Cold Sores ____________

Crowns/Bridges ____________

Deep Cleaning/Periodontal (Gum) Treatment ____________

Fillings ____________

Implants ____________

Oral Cancer ____________

Orthodontic Treatment/Braces ____________

Root Canal Treatment ____________

Sensitive Teeth ____________

Tooth Extraction ____________

Tooth Pain ____________

Other (please specify)

Signature