



# PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

*All answers are kept confidential*

1. Are you in good health Y N
  2. Has there been any change in your general health in the past year? Y N
  3. Date of last physical exam: \_\_\_\_\_
  4. Are you now under a physician's care for a particular problem? Y N  
If yes, for what? \_\_\_\_\_
  5. Have you had any serious illnesses, operations or hospitalizations? Y N  
If so describe: \_\_\_\_\_
  6. Do you have or have you been treated for the following:
    - A. Rheumatic fever or rheumatic heart disease? Y N
    - B. Congenital heart disease? Y N
    - C. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker installed)? Y N
    - D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Y N
    - E. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown? Y N
    - F. Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily? Y N
    - G. Liver disease (jaundice, hepatitis)? Y N
    - H. Kidney disease? Y N
    - I. Diabetes? Y N
    - J. Thyroid disease? Y N
    - K. Arthritis? Y N
    - L. Stomach ulcers or colitis? Y N
    - M. Glaucoma? Y N
    - N. Frequent or recurring mouth sores? Y N
    - O. Implants placed in your body (heart valve, hip, knee)? Y N
    - P. Radiation (x-ray) treatment for cancer? Y N
    - Q. Clicking or popping of jaw joint, pain near ears, difficulty opening mouth, grind or clench your teeth? Y N
    - R. Sinus or nasal problems? Y N
    - S. Any disease, drugs or transplant operation that may suppress your immune system? Y N
    - T. Recurring infections of any kind? Y N
    - U. Sleep apnea? Y N
    - V. Snoring, difficulty breathing during sleep, or mouth breathing during sleep? Y N
  7. Are you using or taking any of the following?
    - A. Tagamet? Y N
    - B. Thyroid medications? Y N
    - C. Antibiotics or sulfa drugs? Y N
    - D. Anticoagulants/blood thinners? Y N
    - E. High blood pressure medicine? Y N
    - F. Steroids, cortisone, etc.? Y N
    - G. Tranquilizers (Valium, etc.)? Y N
    - H. Insulin, Diabinese, or similar drug? Y N
    - I. Digitalis, Inderal, Nitroglycerin, calcium blockers, Procardia or other heart medication? Y N
    - J. Aspirin or Ibuprofen (Motrin, Naprosyn, etc.)? Y N  
How much daily? \_\_\_\_\_
    - K. Antihistamines or other decongestants (Seldane, etc.)? Y N
    - L. Drug(s) to assist in weight loss/gain? Y N
    - M. Any other medications, pills or drugs? Y N

If yes, please specify: \_\_\_\_\_
  8. Are you allergic or have a bad reaction to:
    - A. Local anesthesia (Novocaine, etc.) Y N
    - B. Penicillin, Amoxicillin, Cephalosporins or other antibiotics? Y N
    - C. Barbituates, sedatives, etc.? Y N
    - D. Sulfa and/or sulfites? Y N
    - E. Aspirin or Ibuprofen? Y N
    - F. Codeine or other pain killers? Y N
    - G. Latex or rubber products? Y N
    - H. Eggs? Y N
    - I. Other allergies or reactions? Y N  
If yes, please specify: \_\_\_\_\_
  9. Do you wear contact lenses? Y N
  10. Do you smoke or chew tobacco? Y N  
How much daily? \_\_\_\_\_
  11. Do you use alcohol? Y N  
How much daily? \_\_\_\_\_
  12. Have you ever sought professional care for drug abuse, alcoholism, or emotional disorders? Y N
  13. Do you have any other disease, condition or problem not listed here that you think the doctor should know about? Y N  
If yes, please specify \_\_\_\_\_
  14. Do you wish to talk with the doctor privately about anything? Y N
- WOMEN:
- |   |     |
|---|-----|
| Are you pregnant or planning pregnancy? | Y N |
| Are you taking any birth control pills? | Y N |
| Are you taking hormone replacements?    | Y N |

I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. The information I have provided here is complete and accurate.

Patient/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

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