We would like to learn about your well-being:

Please circle where applicable

Are you in good health? YES NO

Have you been treated by a physician in the past five years for anything other than a routine check-up? YES NO

When? _____ Reason _____

Do you now, or have you ever had a reaction to one of the following: YES NO
Local anesthetic Penicillin Aspirin Latex Other: _____

Have you been advised to pre-medicate prior to any dental treatment? YES NO

List any medications you are currently taking: Medication: Dose:

_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had excessive bleeding that requires special treatment? YES NO

Have you had a blood transfusion in the past 5 years? YES NO

Do you now, or have you ever had any of the following conditions: (Please circle all that apply)

Rheumatic fever	Heart Murmur	Bleeding Problems
Heart Disease	Artificial Joint/Valve	Ulcers
Heart Attack	Diabetes	Epilepsy/Seizures
Angina (Chest Pain)	High Blood Pressure	Fainting Spells
Palpitations	Low Blood Pressure	AIDS or HIV Infection
Stroke	Lung Disease	Liver Disease
Asthma	Tuberculosis	Hepatitis, Jaundice
Other: _____	Other: _____	Other: _____

Women- Are you pregnant? YES NO Month: _____
Are you currently nursing? YES NO
Are you currently taking birth control pills? YES NO

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature:_____Date:_____

Dr._____ Signature: _____ Date: _____