Date of last physical exam:

Are you now or have you recently been under a physician's care? YES

Reason:

Have you ever been a patient in a hospital or had any serious illness? YES

Explain:

Are you currently taking medication? Yes

If so, please list below the name of the medication and what it is for (ie. Lipitor - high cholesterol):

Medication	**U**

	Please
Are you currently a smoker?	YES
Are you allergic or made sick by any medication:	YES
Local anesthetics (novocaine)	YES
Penicillin	YES
Sulfa drugs or other antibiotics	YES
Aspirin, acetaminophen (Tylenol), or ibuprofen (Advil)	YES
Codeine or other narcotics	YES
Any other drugs or medications	
Do you have a PACEMAKER?	YES
if so, which joint and what year was the surgery (ie.left knee,2001).	YES
if so, which joint and what year was the surgery (ie.left knee,2001).	YES
Have you ever had excessive bleeding requiring special treatment?.....Yes No	YES
Are you required to take pre-medication for surgery or prophylaxis treatment?	YES

Please circle any of the following conditions that pertain to you currently or from the past:

Heart Failure/Attack	Emphysema	AIDS/HIV
Heart Disease	Persistent Cough	Hepatitis/Liv
Mitro Valve Prolapse	Tuberculosis	Blood Trans
Heart Murmur	Asthma/Hay Fever	Hemophilia
High Blood Pressure	Sinus Trouble	Epilepsy/Se
Rheumatic Fever	Allergies/Hives	Sickle Cell D
Scarlet Fever	Diabetes	Fainting/Diz
Congenital Heart Lesions	Mononucleosis	Drug Addict
Anemia	Cancer	Venereal Di
Stroke	Radiation Therapy	Genital Herp
Kidney Trouble	Chemotherapy	Cold Sores
Ulcers	Thyroid Disease	Psychiatric
Rheumatism	Glaucoma	Hearing Imp
Asthma		

	Please
Do you have any disease, condition, or problem not listed above? Please explain:	YES

WOMEN:

Are you pregnant?	YES
Are you presently taking any routine medications? (ie:birth control/hormone replacement)	YES

DENTAL HISTORY

	Please
Are you having any pain or discomfort at this time	YES
Do your gums bleed when brushing your teeth?	YES
Do you have any sores or swellings in your mouth?	YES
Do you have jaw pain?	YES
Do you have tension headaches?	YES
Do you have an unpleasant taste or odor in your mouth?	YES
Is there anything about your smile you would like to share?	YES

If yes, please share:

Signature: **Date:**

NO

NO

No

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circle one

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