Have you ever had any of the following?

AIDS/HIV	☐ YES	☐ NO	HEPATITIS TYPE ____	☐ YES	☐ NO
ANEMIA	☐ YES	☐ NO	HERPES	☐ YES	☐ NO
ARTHRITIS	☐ YES	☐ NO	HIGH BLOOD PRESSURE	☐ YES	☐ NO
ARTIFICIAL HEART VALVES	☐ YES	☐ NO	ASTHMA	☐ YES	☐ NO
BACTERIAL ENDOCARDITIS	☐ YES	☐ NO	KIDNEY DISEASE	☐ YES	☐ NO
BLEEDING ABNORMALLY	☐ YES	☐ NO	LIVER DISEASE	☐ YES	☐ NO
BLOOD DISORDER	☐ YES	☐ NO	LOW BLOOD PRESSURE	☐ YES	☐ NO
CANCER	☐ YES	☐ NO	MENTAL OR NERVOUS PROBLEMS	☐ YES	☐ NO
CHEMICAL OR DRUG DEPENDENCY	☐ YES	☐ NO	PACEMAKER	☐ YES	☐ NO
CHEMOTHERAPY	☐ YES	☐ NO	RADIATION TREATMENT	☐ YES	☐ NO
CONGENITAL HEART DISEASE	☐ YES	☐ NO	RESPIRATORY DISEASE	☐ YES	☐ NO
DIABETES TYPE I OR II?	☐ YES	☐ NO	SHORTNESS OF BREATH	☐ YES	☐ NO
EPILEPSY	☐ YES	☐ NO	STOMACH ULCER	☐ YES	☐ NO
FAINTING OR DIZZINESS	☐ YES	☐ NO	STROKE	☐ YES	☐ NO
GASTROINTESTINAL DISEASE	☐ YES	☐ NO	THYROID PROBLEMS	☐ YES	☐ NO
HEADACHES	☐ YES	☐ NO	TUBERCULOSIS	☐ YES	☐ NO
HEART DISEASE	☐ YES	☐ NO	TUMORS	☐ YES	☐ NO

Please list any allergies _____

Please list any medications you are currently taking: _____
_____

Women: Are you currently pregnant? YES_____ NO____ What trimester? _____

Do you use tobacco? YES____ NO____ Do you experience dry mouth? YES_____ NO_____

Do your gums bleed? YES___ NO____ Have you had previous gum surgery? YES_____ NO_____

Do you find yourself clenching or grinding your teeth? YES_____ NO_____

Do you have aches in the jaw joint, face muscles? YES_____ NO_____

Have you had orthodontic work (braces)? YES_____ NO_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian_____ Date_____