Please help us by answering the following questions regarding your medical history. Thank you!

Name_____ Date_____

Have you had or do you have any of the following conditions? (please circle)

Asthma	Yes	No	Tuberculosis	Yes	No
Allergies or hay fever	Yes	No	Chest pain	Yes	No
Sinus problems	Yes	No	Emphysema	Yes	No
Any other lung condition	Yes	No	Fever blisters/cold sores	Yes	No

High blood pressure	Yes	No	Heart beat irregularity	Yes	No
Heart attack	Yes	No	Mitral valve prolapse	Yes	No
Heart valve problem	Yes	No	Stroke	Yes	No

Do you have a cardiac pacemaker? Yes No
Do you need to take antibiotics before dental work or other procedures? Yes No

Bleeding problems	Yes	No	Other bone or joints problems	Yes	No
Arthriitis	Yes	No			

Do you take aspirin, ibuprofen or other similar medications on a regular basis? Yes No

Liver problem	Yes	No	Thyroid condition	Yes	No
Hepatitis	Yes	No	Diabetes	Yes	No
Kidney problem	Yes	No	Cancer	Yes	No
Chronic infections	Yes	No	HIV	Yes	No

Please explain any “yes” answers to the above questions, including treatment if applicable:

Are you allergic to any medications? Yes No If yes, please list:

Are you currently taking any medications? Yes No If yes, please list:

Have you had any surgery or operations? Yes No If yes, please list, including approximate date:

Have you ever smoked? Yes No If yes, when and for how long?

Have you ever had a local anesthestic? Yes No
Have you ever been told not to take novocaine? Yes No

When was your last general physical exam?

Are there any conditions that run in your family? (Please list)