



1. Have you been under the care of a physician for a medical condition in the last two years?..... Yes No
If yes, please explain _____
2. Have you ever had cancer?..... Yes No
If so, how was it treated? Chemotherapy Radiation Other
3. Have you had a heart attack?..... Year _____ Yes No
4. Have you ever been told that you need antibiotics prior to dental treatment?..... Yes No
5. Do you smoke?..... Packs Per Day _____ Yes No
6. Do you have pain in your chest or shortness of breath? Yes No
7. Do your ankles swell during the day? Yes No
8. Do you ever wake up from sleep short of breath? Yes No
9. Do you snore at night? Yes No
10. Have you taken any illegal drugs in last five years? Yes No
11. Is there a possibility that you might be pregnant? Yes No
12. Have you ever had the inability to get "numb" from local anesthetics? Yes No
13. Have you had a bad dental experience in the past? Yes No

14. List any prescriptions you are taking. _____

15. Please check YES or NO to the following health conditions

| | Yes | No | | Yes | No | | Yes | No |
|--------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| AIDS | <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorders | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valve | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina Pectoris | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Artificial joints | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart lesions | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Bruise easily | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Cold sores | <input type="checkbox"/> | <input type="checkbox"/> | HIV | <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to: | | |
| Chronic coughs | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> | | Yes | No |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Codiene | <input type="checkbox"/> | <input type="checkbox"/> |

Your Signature _____ **Date** _____

FOR OFFICE USE ONLY

| Date | Doctor | ASA | Date | Doctor | ASA |
|-------|--------|-------|-------|--------|-------|
| _____ | _____ | _____ | _____ | _____ | _____ |