HEALTH INFORMATION

Approximate Name: Approximate of Medical Doctor: Have you ever had any of the following? Please answer all questions by marking VFS or NO. If you are not sure, do not assessment of your medical conditions. If you have any hestations, please discuss your concern with one of the staff members. Cardiovascular Remained Females Fe	D.C. (N	MEALTH INFO		D (177.1)
Have you ever had any of the following? Please answer all questions by marking YES or NO. If you are not sure, do not assessment of your medical conditions. If you have any hesitations, please discuss your concern with one of the staff members. Premise Yes No. Yes No. High Blood Pressure				
answer the question. Your response to this questionnaire will be held strictly confidential and will only be used to assist in the sassessment of your medical conditions. If you have any hesitations, please discuss your concern with one of the staff members. Cardiovascular				
assessment of your medical conditions. If you have any hesitations, please discuss your concern with one of the staff members. Yes No Yes No Hematologic/Endocrine/Immune Yes No Left High Blood Pressure Left Congenital Heart Discusse Rehematics Fever Rehematics Fever Rehematics Fever Performents Rehematics Fever Remains Fever Rehematics Fever Remains Fever Rehematics Fever Rehematics Fever Remains Fever Fever Remains				
Cardiovascular				
Ves No	assessment of your medical conditions. If y	ou have any hesitations, ple	ease discuss your cond	eern with one of the staff members.
Ves No	Cardiovascular	Females	Не	ematologic/Endocrine/Immune
Hat Marmar				
□ Congenital Heart Disease □ Rhemartic Fever □ Heart Murmur □ Heart Murmur □ Heart Murmur □ Heart Mymars □ Vascular Graft □ Heart Phymas Surgery □ Heart Phymas Surgery □ Artificial Heart Valve □ Congestive Heart Failure □ Congestive Trailers □ Congestive T		☐ Are you pregnant nov		
Alternation Antennation				☐ Denied permission to give blood
Heart Mamur				
Heart Pacemaker	☐ ☐ Heart Murmur			
General Spass Surgery	☐ ☐ Heart Pacemaker	□ □ Do you anticipate bed	coming	
Grant of Bypass Surgery	□ □ Vascular Graft			☐ Blood clots or thrombosis
Artificial Hard Valve	☐ ☐ Heart or Bypass Surgery	☐ Are you breast feeding	ig now? □	☐ Diabetes Type I / II
Gongestive Heart Failure	☐ Artificial Heart Valve			☐ Thyroid Disease
Awaken with breathing difficulty	☐ Congestive Heart Failure			☐ Adrenal Gland Disease
Angina Pectoris/Chest Pain				
Have you ever taken Prescription diet pilst. Example: PhenFer? Unexplained Visual Changes Bleeding or Bruising Tendency pilst. Example: PhenFer? Unexplained Visual Changes Sudolen Ankles Artificial Joint Frequent Thirst Frequent T			s of consciousness	☐ HIV Infection
pills, Examplic: PhenFen? Unexplained Visual Changes Swollen Ankles Arthricial Joint Arthricial Joint Frequent Phirst Frequent				
Irregular or rapid heart beat?	1 1		Changes	
Stroke/TIA				
Have you ever taken antibiotics before a Spinal cord injury/paralysis dental appointment? Cerebral Palsy Systemic Lupus Psychiatric		☐ Arthritis or Bone Dis	cusc	
dental appointment?				
Taken steroids/prednisone		□ □ Spinal cord injury/pa	iaiysis	
Respiratory		□ □ Cerebral Palsy		
Ves No				
Emphysema or Asthma				s No
Hay Fever/Seasonal Allergies				
Chronic cough or Bronchitis Cough up bloody sputum Chronic Sinus Infections Chronic Sinus Infections Chronic Sinus Infections Shortness of Breath Do you use a CPAP? Do you use a CPAP? Chigarettes Smokeless Smokeless Smokeless Smokeless Smokeless Smokeless Smokeless Smokeless For how long? If you quit, how long ago? Frequent cold sores Frequent Cold sores Chronic diarrhea How much did you smoke? Chronic diarrhea Do you have any other conditions not already mentioned? Current Medication: Please list the prescribed and/or over the counter medications you have taken within the last six months. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.				
Cough up bloody sputum Cromic Sinus Infections Castrointestinal/Genitourinary Penicilin/Sulfa Drugs Penicilin/Sulfa Dr				
□ Tuberculosis (TB)				
Chronic Sinus Infections Shortness of Breath Do you use a CPAP? Hepatitis or other liver disease Do you use tobacco? Do you use tobacco? Smokeless Smokeless Smokeless Smokeless Smokeless Smokeless Smokeless Sevally Transmitted Disease How much? For how long? Frequent canker sores If you quit, how long ago? Frequent load sores How much did you smoke? Frequent Vomitting Bleeding Disorders Smoking Do you have any other conditions not already mentioned? History of hospitalization/surgical procedures: Current Medication: Please list the prescribed and/or over the counter medications you have taken within the last six months. Please include dosages and the condition requiring the medication. DOSAGE CONDITION REQUIRING THIS MEDICATION To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.				<u>lergies</u>
Shortness of Breath Do you use a CPAP? Hepatitis or other liver disease Do you use tobacco? Hepatitis or other liver disease Other dental anesthetics Do you use tobacco? Jaundice Asprini/Codeine Latex products Latex products Metals, including jewelry Metals, i		Gastrointestinal/Genit	<u>tourinary</u> Yes	s No
Do you use a CPAP?		Yes No		☐ Penicillin/Sulfa Drugs
Do you use tobacco?				☐ Novocaine/Xylocaine and
Cigarettes		☐ ☐ Hepatitis or other live	er disease	
Smokeless Smokeless Syphilis, gonorrhea or other Syphilis, gonorrhea or other Sexually Transmitted Disease Gher Sexually Transmitted Disease Family History of Disease Family Histor				
Pipe			lant	
Other				
How much?				
For how long?		_		mily History of Disease
If you quit, how long ago? Frequent cold sores Heart Disease Chronic diarrhea Tuberculosis(TB) Bleeding Disorders Smoking Smoking Bleeding Disorders Smoking Current Medications not already mentioned? Frequent Vomitting Bleeding Disorders Smoking Current Medication: Please list the prescribed and/or over the counter medications you have taken within the last six months. Please include dosages and the condition requiring the medication. MEDICATION DOSAGE CONDITION REQUIRING THIS MEDICATION CLEARANCE CONDITION REQUIRING THIS MEDICATION CLEARANCE Condition of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.				s No
How much did you smoke? Chronic diarrhea Tuberculosis(TB) Bleeding Disorders Smoking Smoking Current Medication: Please list the prescribed and/or over the counter medications you have taken within the last six months. Please include dosages and the condition requiring the medication. MEDICATION DOSAGE CONDITION REQUIRING THIS MEDICATION CLEARANCE Current Medication: Please list the prescribed and/or over the counter medications you have taken within the last six months. CONDITION REQUIRING THIS MEDICATION CLEARANCE Condition: Please include dosages and the condition requiring the medication. MEDICATION DOSAGE CONDITION REQUIRING THIS MEDICATION CLEARANCE Condition: Please include dosages and the condition requiring the medication. MEDICATION DOSAGE CONDITION REQUIRING THIS MEDICATION CLEARANCE Chronic diarrhea Tuberculosis(TB) Bleeding Disorders Smoking Current Medication: Please list the prescribed and/or over the counter medications you have taken within the last six months. Please include dosages and the condition requiring the medication. MEDICATION DOSAGE CONDITION REQUIRING THIS MEDICATION CLEARANCE Chronic diarrhea Tuberculosis(TB) Current Medication: Please list the prescribed and provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.			S	□ Diabetes
How much did you smoke?	if you quit, now long ago?			
Do you have any other conditions not already mentioned? History of hospitalization/surgical procedures: Current Medication: Please list the prescribed and/or over the counter medications you have taken within the last six months. Please include dosages and the condition requiring the medication. MEDICATION DOSAGE CONDITION REQUIRING THIS MEDICATION CLEARANCE	How much did you smake?			
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		ctors at tne next appointm		

OCCLUSAL SCREENING

YES	NO
	□ Do you clench or grind your teeth during the day?
	☐ Have you been made aware of clenching or grinding your teeth at night?
	☐ Do you have frequent headaches, neck or shoulder pain?
	☐ Are your jaws or teeth tired when you awaken?
	☐ Have you ever had pain in your jaw joint, the sides of your face or ears?
	☐ Have your jaws ever clicked or popped when you open your mouth?
	☐ Have you ever experienced difficulty moving your jaw or opening your mouth?
	□ Do you chew on only one side of your mouth?
YES	DENTAL HISTORY NO
	 Are you having pain or discomfort related to your mouth? Do you feel nervous about having dental treatment?
	☐ Have you ever had a bad experience in a dental office?
	☐ Have you ever had any complications following dental treatment?
	If yes, please explain:
	11 yes, pieuse expium
Reaso	on for your visit today:
	wed by Dr. Date: