

BASIC ADULT GENERAL HEALTH INFORMATION

Your Name _____

Today's Date ___/___/___

It is important that we understand your health history. It has a direct bearing on your dental health in general and your safety during treatment. This information is confidential and is not released to anyone without your permission. Thank you for helping us take good care of you.



Is there a health concern you prefer to only discuss privately with the doctor? [] YES [] NO



Do You Have, or Have You Have Ever Had, Any Of The Following:

YES NO

(please check YES or NO for EACH item)

- Heart Attack or Heart Disease
- Angina Pectoris (Chest Pain)
- Heart Murmur
- Mitral Valve Prolapse
- Congenital Heart Lesion
- Artificial Heart Valve
- Heart Pacemaker
- Heart Surgery
- Rheumatic Fever
- Infectious Endocarditis
- Have You Used Phen-fen For Weight Loss?
- High Blood Pressure
- Low Blood Pressure (Chronic)
- Stroke
- Diabetes (which type?) _____
- Hypoglycemia (Low Blood Sugar)
- Hepatitis A (Infectious Hepatitis)
- Hepatitis B (Serum Hepatitis)
- Hepatitis C Or Other Form Of Hepatitis
- Any Other Liver Disease Or Jaundice
- Any Kind Of Kidney Disease Or Disorder
- Anemia
- Any Other Blood Disorder
- Episodes of Prolonged Bleeding
- Any Other Bleeding Problem
- Bruise Easily
- Bone Or Calcium Disorder
- Epilepsy Or Other Seizure Disorder
- Chronic Bronchitis Or Emphysema (which?)
- Asthma
- Lyme Disease
- Tuberculosis (TB)

YES NO

(please check YES or NO for EACH item)

- Any Other Lung Or Respiratory Problem
- Significant Snoring (Has Disturbed Others)
- Sleep Apnea (Diagnosed by MD or Sleep Lab)
- Hay Fever
- Thyroid Disease Or Disorder
- Artificial Joint (Hips, Knees, Other)
- Arthritis
- Pain In Jaw Joint(s)
- Frequent Or Chronic Headaches
- Nerve or Neurological Problem
- Just Plain Depressed A Lot
- Ulcer Or Other Gastro-Intestinal Disorder
- Have You Used Any Prescription Drugs For
The Prevention Of Osteoporosis?
- Glaucoma Or Other Eye Disease
- Skin Or Dermatologic Problem
- Cortisone Treatment
- Venereal Disease
- Herpes
- Frequent Cold Sores Or Fever Blisters
- Alcoholism
- Any Other Drug Or Chemical Dependency
- HIV Positive
- AIDS
- Tumor Or Malignancy (Cancer)

- Radiation Treatment Or Chemotherapy
- Surgery In The Past Five Years
(What? _____)
- Other Medical Or Health Problem (what is it?)

(Women): Are You Pregnant? NO YES (Due ___/___/___) Are You Now Breast-Feeding A Baby? NO YES



PLEASE COMPLETE THE OTHER SIDE ALSO



Basic Adult General Health Information (Continued)

Do You Smoke Cigarettes? No Yes If Yes, How Many Packs A Day _____
Do You Smoke A Pipe? No Yes Cigars? No Yes How Many A Day? _____
Are You Trying To Quit Smoking Now? No Yes Have You Quit Smoking Before? No Yes

Are You Allergic To Or Have You Reacted Badly To Any Of The Following Medications?

(please circle which)

Actually Allergic: Aspirin Codeine Local Anesthetic Nitrous Oxide Penicillin Other _____
 Reacted Badly: Aspirin Codeine Local Anesthetic Nitrous Oxide Penicillin Other _____

Are You Allergic To Latex? No Yes (please give details):

Are You Allergic Or Reacted Badly To Anything Else? No Yes (please give details):

Please List, As Specifically As Possible, Any And All Drugs And Medications, Prescription Or Non-Prescription, That You Are Currently Taking Or Regularly Use.

What Is Your Height? _____ Your Present Weight? _____
Weight Changed In The Past Year? No Yes (went up) _____ lbs. (went down) _____ lbs.

Your Personal Physician(s): _____
(Addresses, please)

I authorize Dr. Ross to discuss my health status in connection with my dental treatment with other doctors who care for me or may care for me, and authorize those doctors to discuss my health with Dr. Ross.

Your Signature, Please _____ **Date** ____/____/____

Reviewed By Doctor _____ **Date** ____/____/____