

HEALTH QUESTIONNAIRE & MEDICAL INFORMATION

DO YOU HAVE OR HAVE EVER HAD:

Heart Disease	YES	NO	Venereal Disease/STD's	YES	NO
Specific Heart Disease Listed Below			Kidney Problems	YES	NO
Angina	YES	NO	Respiratory Problems	YES	NO
Arteriosclerosis	YES	NO	For example: Asthma/Emphysema	YES	NO
Heart Murmur	YES	NO	Hepatitis, Jaundice	YES	NO
Congestive Heart Failure	YES	NO	Anemia	YES	NO
Heart Attack	YES	NO	Night Sweats	YES	NO
Mitral Valve Prolapse	YES	NO	Unexplained Weight Loss/Fever	YES	NO
Pacemaker Surgery	YES	NO	Blood Transfusion	YES	NO
Bypass Surgery	YES	NO	Test for HIV for AIDS	N/A	POS NEG
High Blood Pressure	YES	NO	Test for TB	N/A	POS NEG
Low Blood Pressure	YES	NO	Radiation Treatment	YES	NO
Rheumatic Fever	YES	NO	Chemotherapy	YES	NO
Cholesterol Problems	YES	NO	Cancer: Please list with year	YES	NO
Diabetes	YES	NO			
Dry Mouth	YES	NO			
Joint Replacement or Damage	YES	NO			
Seizures	YES	NO	Surgery: Please list with year	YES	NO
Fainting Spells	YES	NO			
Stomach Ulcers	YES	NO			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO:

Any local anesthetics	YES	NO	Codeine	YES	NO
Barbituates, Sedatives, Valium	YES	NO	Aspirin or Ibuprofen	YES	NO
Heart Medications	YES	NO	Latex	YES	NO
Penicillin or any other antibiotics	YES	NO	Other allergies: please list	YES	NO

ARE YOU TAKING ANY OF THE FOLLOWING:

Anticoagulants (blood thinners)	YES	NO	Nitroglycerin	YES	NO
Aspirin/Anti-inflammatory drugs	YES	NO	Antibiotics or Sulfa Drugs	YES	NO
Heart Medications	YES	NO	Cortisone or Steroids	YES	NO
Medicines for High Blood Pressure	YES	NO	Tranquilizers or Antidepressants	YES	NO
Insulin, Micronase	YES	NO	Birth Control Pills	YES	NO

List Medications Currently Taking	Dosage	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Have you ever had to be premedicated for dental work? YES NO
- Please describe any current or recent medical treatment, impending operations, pregnancies, or other information we should be aware of: _____