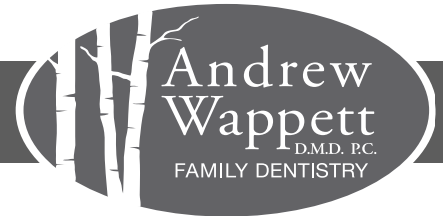


HEALTH HISTORY



PLEASE FILL IN THE FOLLOWING INFORMATION.

MEDICAL DOCTOR _____ LAST PHYSICAL EXAM _____

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? YES NO

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING OR HAVE TAKEN OVER THE LAST 2 MONTHS. (INCLUDING PRESCRIPTIONS, SUPPLEMENTS AND OVER THE COUNTER MEDICINES. _____

DO YOU HAVE ANY CONCERNS ABOUT RECEIVING DENTAL TREATMENT? YES NO

IF YES, PLEASE SPECIFY _____

<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p><input type="checkbox"/> DO YOU HAVE A TOOTHACHE NOW?</p> <p><input type="checkbox"/> ARE YOU ALLERGIC TO ANY MEDICATIONS?</p> <p>_____</p> <p>_____</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p><input type="checkbox"/> DO YOU USE TOBACCO?</p> <p><input type="checkbox"/> DO YOU DRINK ALCOHOL?</p> <p><input type="checkbox"/> DO YOU USE OTHER DRUGS?</p> <p><input type="checkbox"/> ASTHMA?</p> <p><input type="checkbox"/> ANEMIA?</p> <p><input type="checkbox"/> ARTHRITIS/RHEUMATISM?</p> <p><input type="checkbox"/> CHEST PAINS?</p> <p><input type="checkbox"/> CANCER OR TUMORS?</p> <p><input type="checkbox"/> EPILEPSY OR SEIZURES?</p> <p><input type="checkbox"/> HEPATITIS/LIVER PROBLEMS?</p> <p><input type="checkbox"/> KIDNEY PROBLEMS?</p> <p><input type="checkbox"/> LUPUS?</p> <p><input type="checkbox"/> NERVOUS OR MENTAL DISORDERS?</p> <p><input type="checkbox"/> SINUS TROUBLE?</p> <p><input type="checkbox"/> STROKE?</p> <p><input type="checkbox"/> TUBERCULOSIS OR LUNG DISEASE?</p> <p><input type="checkbox"/> ULCERS?</p> <p><input type="checkbox"/> DO YOU HAVE REASON TO BELIEVE YOU HAVE BEEN EXPOSED TO AIDS OR HIV?</p> <p><input type="checkbox"/> DO YOU HAVE ANY DISEASES, CONDITIONS, OR PROBLEMS NOT LISTED? IF SO, WHAT?</p> <p>_____</p>
<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>DO YOU HAVE A MEDICAL HISTORY OF:</p> <p><input type="checkbox"/> DIABETES?</p> <p><input type="checkbox"/> HIGH BLOOD PRESSURE?</p> <p><input type="checkbox"/> HEART SURGERY?</p> <p><input type="checkbox"/> HEART VALVE OR PACEMAKER?</p> <p><input type="checkbox"/> HEART INFECTION? (INFECTIVE ENDOCARDITIS)</p> <p><input type="checkbox"/> HEART ATTACK</p> <p>SPECIFY ANY HEART RELATED PROBLEMS</p> <p>_____</p> <p><input type="checkbox"/> ARTIFICIAL JOINT? _____</p> <p><input type="checkbox"/> HAVE YOU EVER, OR DO YOU NOW TAKE BISPHTHONATE MEDICATIONS?</p> <p>FOSAMAX, BONIVA, ACTONEL, ZOMETA, DIDRONEL, AREDIA, SKELID</p> <p><input type="checkbox"/> MEDICAL CARE IN THE LAST 2 YEARS?</p> <p><input type="checkbox"/> HOSPITALIZATIONS?</p> <p>IF SO, WHY? _____</p> <p><input type="checkbox"/> BLEEDING PROBLEMS THAT NEEDED MEDICAL TREATMENT? WHAT?</p> <p>_____</p>	<p>FEMALES ONLY</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p><input type="checkbox"/> ARE YOU CURRENTLY: PREGNANT?</p> <p><input type="checkbox"/> TAKING BIRTH CONTROL PILLS?</p> <p><input type="checkbox"/> NURSING?</p>

AS OF (TODAY'S DATE) _____ THE INFORMATION I HAVE PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE. MY SIGNATURE INDICATES THAT I GIVE MY CONSENT FOR ROUTINE DENTAL PROCEDURES, SUCH AS X-RAYS, CLEANINGS, FILLINGS, CROWNS, AND LOCAL ANESTHESIA.

PATIENT OR PARENT/GUARDIAN

DR. WAPPETT

PATIENT NAME

DATE OF BIRTH