ARE YOU ALLERGIC TO ANY MEDICATIONS?
IF SO, WHAT?_____

DO YOU HAVE A LATEX ALLERGY? Y OR N

ANY CHANGES IN YOUR HEALTH IN THE LAST YEAR? Y / NO
IF YES, EXPLAIN_____

HAVE YOU BEEN HOSPITALIZED, IN THE ER OR HAD A SERIOUS ILLNESS IN LAST 3 YEARS? Y OR NO
IF YES, EXPLAIN_____

ARE YOU BEING TREATED BY A PHYSICIAN NOW? Y OR N
IF YES, REASON _____

DATE OF LAST MEDICAL EXAM_____
REASON FOR EXAM_____

NAME OF MEDICAL PHYSICIAN_____ PHONE #_____

HAVE YOU HAD PROBLEMS WITH PRIOR DENTAL TREATMENT? Y OR NO
IF YES, EXPLAIN_____

DO YOU USE TOBACCO PRODUCTS? Y OR N

<u>WOMEN ONLY</u>

ARE YOU PREGNANT Y OR N
ARE YOU NURSING Y OR N

DO YOU HAVE ANY OTHER DISEASE OR HEALTH PROBLEMS WE SHOULD BE AWARE OF? _____

SIGNATURE_____ **DATE**_____