

3. Have you ever had breathing difficulty such as asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any other lung disorder? [] YES [] NO

4. Do you smoke? [] YES [] NO If YES, how much? _____

TELL US ABOUT ANY SURGERIES OR HOSPITALIZATIONS

**Circle any of the following which you have or had in the past:*

- | | | |
|--------------------------|-----------------------|--------------------------|
| Heart Failure | Emphysema | Hepatitis A (infectious) |
| Heart disease or attack | Cough | Hepatitis B (serum) |
| Angina Pectoris | Tuberculosis | Liver Disease |
| High Blood Pressure | Asthma | Jaundice |
| Heart Murmur | Hay Fever | Blood Transfusion |
| Rheumatic Fever | Sinus Trouble | Drug Addiction |
| Congenital Heart Lesions | Allergies or Hives | Hemophilia |
| Scarlet Fever | Diabetes | Venereal Disease |
| Artificial Heart Valve | Thyroid Disease | Genital Herpes |
| Heart Pacemaker | x-ray or Cobalt x-ray | Epilepsy or Seizures |
| Heart Surgery | Chemotherapy | Fainting or Dizzy Spells |
| Artificial Joint | Arthritis | Psychiatric Treatment |
| Anemia | Rheumatism | Sickle Cell Disease |
| Stroke | Cortisone Medication | Bruise Easily |
| Kidney Trouble | Glaucoma | Latex Allergy |
| Ulcers | Pain in Jaw Joints | HIV/AIDS |

5. Are you allergic to ANY medications? [] YES [] NO

If YES, what? _____

6. Have you ever had undesirable effects from taking these drugs? If YES, please circle.

- | | | | |
|---------------------|---------------|-------------|----------------|
| General Anesthetics | Pain Killers | Antibiotics | Sleeping Pills |
| Local Anesthetics | Cortizone | Laxatives | Sedatives |
| Vitamins | Tranquilizers | Stimulants | Mouth Wash |

7. Do you have popping or clicking in your jaw? [] YES [] NO

8. Have you had TMJ problems in the past? [] YES [] NO

9. Do you bleed easily or for long periods? [] YES [] NO

10. Do you now have a cold, cough or sinus trouble? [] YES [] NO

11. Do you wear contact lenses? [] YES [] NO

12. If female...are you pregnant? [] YES [] NO

13. When you walk up stairs or exercise, do you ever experience chest pain or shortness of breath or have to stop simply because you are very tired? [] YES [] NO

14. Do your ankles swell during the day? [] YES [] NO

15. Do you use more than 2 pillows to sleep? [] YES [] NO

16. Do you have any disease, problem, or condition not listed above? [] YES [] NO

17. ARE YOU ALLERGIC TO EGGS OR SOY [] YES [] NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my medical history (including changes in medicine) or health, I will inform the doctor of dentistry at my next appointment.

Signed _____ Date _____ Updated: _____ Signed _____

Updated _____ Signed _____

Updated _____ Signed _____

BP _____ Pulse _____ PulseOx RA _____

CHIEF COMPLAINT _____

AAOMS VIDEO VIEWED [] YES [] NO Date _____

History Reviewed By: _____

NOTES: