MEDICAL HISTORY (ALL RESPONSES ARE KEPT CONFIDENTIAL)

Patient's Name	General Dentist	Referring Doctor	Medical Doctor	Height	Weight

Answer all questions by circling YES (Y) or No (N)

1. Have you ever had any adverse effects from dental treatment? .... Y N
2. Do you wear a denture or removable appliance? Y N
3. Clicking or Popping of the Jaw Joint, Pain Near Ear, Difficulty Opening Mouth, Grind or Clench Teeth?........ Y N
4. Have you or a family member had problems with general anesthesia?........ Y N
5. Do you snore or have you been diagnosed with sleep apnea?........ Y N
6. Do you smoke or chew tobacco?........ Y N
7. Do you use Marijuana or other "street drugs"?.... Y N
8. Do you use alcohol? .... Y N
9. Are you pregnant or nursing?........ Y N
   If yes, how many months ______________________
10. Do you wear contact lenses?........ Y N
11. Are you wearing any oral piercings?........ Y N

Are you taking any of the following medications:
If yes, please indicate name of medication(s).

1. Thyroid Medications........ Y N
2. Antibiotics or Sulfa Drugs .... Y N
3. Anticoagulants (Blood Thinners)........ Y N
4. High blood Pressure Medicine........ Y N
5. Steroids (Cortisone, etc.) .... Y N
6. Tranquilizers (Valium, etc.)........ Y N
7. Insulin or Anti-Diabetic drug........ Y N
8. Digitalis, Inderal, Nitroglycerin,Calcium Channel Blockers, Procardia, or other Heart Medicine?... Y N
9. Aspirin or Ibuprofen .... Y N
   If so, how much daily ____________________
10. Antihistamines or Decongestants........ Y N
11. **PLEASE LIST ALL MEDICATIONS YOU ARE TAKING ON THE BACK SIDE OF THIS FORM.**

Are you allergic or had a bad reaction to: If answering yes, please circle condition(s).

1. Local Anesthetic (Novocaine, etc.)........ Y N
2. Penicillin, Amoxicillin, Cephalosporins or other Antibiotics........ Y N
3. Barbiturates, Sedatives, etc........ Y N
4. Aspirin or Ibuprofen .... Y N
5. Codeine or other Pain Killers .... Y N
6. Latex or Rubber Products .... Y N
7. Eggs .... Y N
8. Soybeans........ Y N
9. Sulfa .... Y N
9. Other Allergies or Reactions________________Y N

Do you have or have you ever had: If answering yes, please circle condition(s) that pertains to you.

1. Scarlet or Rheumatic Fever .... Y N
2. Congenital heart disease .... Y N
3. Cardiovascular Disease/Heart Condition...... Y N
   - Angina........ Y N
   - Heart murmur........ Y N
   - Heart attack: if yes, when___________ Y N
   - Heart surgery: if yes, when__________ Y N
   - High blood pressure........ Y N
   - Low blood pressure........ Y N
   - Pacemaker........ Y N
   - Stroke........ Y N
4. Lung Disease
   - Asthma........ Y N
   - Emphysema........ Y N
   - Bronchitis........ Y N
   - Tuberculosis........ Y N
   - Shortness of breath........ Y N
   - Pneumonia........ Y N
5. Bleeding Disorder
   - Anemia........ Y N
   - Bleed or bruise easily........ Y N
6. Nervous Disorder
   - Epilepsy/Seizures........ Y N
   - Fainting .... Y N
   - Psychiatric treatment........ Y N
7. Liver Disease (Jaundice, Hepatitis) .... Y N
8. Kidney Disease .... Y N
9. Diabetes .... Y N
10. Thyroid Disease .... Y N
11. Arthritis .... Y N
12. Stomach Ulcers or Colitis........ Y N
13. Glaucoma........ Y N
14. Bone disease
    - Medications ________________________
15. Treatment for Cancer
    - Surgery........ Y N
    - Radiation........ Y N
    - Chemotherapy........ Y N
    - Oral cancer drugs........ Y N
16. Immune System .... Y N
    - HIV/AIDS........ Y N
17. Have you had an organ or tissue transplant…Y N
18. Frequent or Recurring Mouth Sores .... .Y N
19. Implants placed anywhere in your body (Heart Valve, Hip, Knee)........ Y N
20. Sinus or Nasal Problems?........ Y N

- Do you have any other disease or condition not listed above that the doctor should know about?........ Y N
  If yes, please list ______________________________
- Do you wish to talk to the doctor privately about anything? .... Y N

For Women Only:

- Antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please advise the doctor if there is any chance of your being pregnant.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

Date	Signature of person completing Health History	Doctor's Initials

DRS. DELGADO & KUZMIK, P.C.

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MEDICATION	STRENGTH	FREQUENCY

PATIENT SIGNATURE ______________________

DATE ______________