IV. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

YES / NO	Heart disease	YES / NO	AIDS/HIV+/ARC	YES / NO	Psychiatric care
YES / NO	Family of heart disease	YES / NO	Surgeries	YES / NO	Osteoporosis
YES / NO	Artificial Valves	YES / NO	Hospitalization	YES / NO	Thyroid problems
YES / NO	Heart attack	YES / NO	Diabetes/Hypoglycemia	YES / NO	Asthma
YES / NO	Heart surgery/Pacemaker	YES / NO	Family history of diabetes	YES / NO	Hepatitis
YES / NO	Artificial joints/bones	YES / NO	Tumors or cancer	YES / NO	Sexually transmitted disease
YES / NO	Stomach problems or ulcers	YES / NO	Leukemia	YES / NO	Herpes
YES / NO	Heart defects	YES / NO	Chemotherapy	YES / NO	Canker or cold sores
YES / NO	Heart murmurs	YES / NO	Radiation or cobalt treatment	YES / NO	Alcohol or drug abuse
YES / NO	Rheumatic fever	YES / NO	Arthritis/Rheumatism	YES / NO	Anemia
YES / NO	Mitral valve prolapse	YES / NO	Emphysema	YES / NO	Liver problems
YES / NO	Skin disease	YES / NO	Kidney or bladder problems	YES / NO	Glaucoma
YES / NO	Hardening of arteries	YES / NO	Stroke	YES / NO	Transplants
YES / NO	High blood pressure	YES / NO	Eating disorders	YES / NO	Tuberculosis
YES / NO	Seizures/Epilepsy	YES / NO	Migraines	YES / NO	Respiratory problems
YES / NO	Shingles	YES / NO	Cosmetic surgery	YES / NO	Scarlet fever

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or NO for each)

YES / NO	Recreational drugs	YES / NO	Tobacco in any form	YES / NO	Antibiotics
YES / NO	Over-the-counter medicines	YES / NO	Alcohol	YES / NO	Supplements
YES / NO	Weight loss medications	YES / NO	Stimulants	YES / NO	Aspirin
YES / NO	Tranquilizers	YES / NO	Insulin	YES / NO	Blood thinners
YES / NO	Muscle relaxers	YES / NO	Pain killers	YES / NO	Nerve pills
YES / NO	Bisphosphonate (Fosamax)				

VI. WOMEN ONLY (Please circle Yes or No for each)

YES / NO Are you or could you be pregnant? If YES, what month? _____

YES / NO Are you nursing?

YES / NO Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

YES / NO Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

YES / NO Have you ever been pre-medicated for dental treatment ? If YES, why: _____

YES / NO Have you ever taken Fen-Phen? If YES, when: _____

YES / NO Do you wear contact lenses?

YES / NO Is there any issue or condition you would like to discuss with the dentist in private?