

Patient Name: _____ Initial Date: _____

HEALTH INFORMATION

Personal Physician: _____

Address of Practice: _____

YES NO

- Have you been hospitalized within the past 2-years? What For? _____
- Is a physician currently treating you? What For? _____
- Are you currently taking any medications or drugs? Please List: _____
- Do you smoke or chew tobacco? _____
- Are you allergic to any medications or drugs? Please List: _____
- Do you pre-medicate for dental work?
- Are you allergic to any metals? Please List: _____
- Have you ever had a skin rash or other reaction to metal jewelry?

Women Only:

- Are you pregnant?
- Are you taking contraceptives? (NOTE: Antibiotics can render certain contraceptives ineffective).
- Are you taking replacement hormones?

CIRCLE ANY IF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD

AIDS	Heart Murmur	Low Blood Pressure
Arthritis	Heart Condition	Rheumatic Fever
	Describe: _____	
Asthma	Hepatitis	Sexually Transmitted Diseases
	High Blood Pressure	Stroke
Cancer	Jaundice	Tuberculosis
Diabetes	Joint Replacement	Other Diseases List: _____
Epilepsy	Kidney Problems	
Glaucoma		

PERSON TO BE CONTACTED IN THE EVENT OF EMERGENCY

Name _____ Address _____ Phone Number _____
Patient Signature (or Parent if Minor) _____

Reviewed By: _____ Date: _____