PRINT NAME_____AGE_____HEIGHT_____WEIGHT_____

AFTER REVIEWING THE FOLLOWING QUESTIONS CIRCLE YES OR NO. YOUR ANSWERS ARE FOR OUR RECORDS AND WILL BE CONSIDERED CONFIDENTIAL

Have there been any changes in your general health within the past year ---------- Yes No
Are you now under the care of a physician (other than routine physicals)---------- Yes No
Have you ever been hospitalized---------- Yes No
Have you ever had any serious illness, operation or injury---------- Yes No
If so what and when_____
Are you taking any drugs or medications at the present time---------- Yes No
If so what_____
Are you allergic to or had a reaction to any drugs or medications---------- Yes No
If so what_____
Are you allergic to or had a reaction to eggs, iodine or latex---------- Yes No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

Hip, knee or any joint replacement---------- Yes No
If so what and when_____
Rheumatic fever, rheumatic heart disease, heart murmur, bacterial endocarditis---------- Yes No
Cardiovascular disease, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, Arteriosclerosis, stroke, congestive heart failure---------- Yes No
Do you have chest pain upon exertion---------- Yes No
Do your ankles swell---------- Yes No
Do you get short of breath when you lie down or require extra pillows to sleep---------- Yes No
Asthma, bronchitis, TB or emphysema---------- Yes No
Fainting spells or seizures---------- Yes No
Sleep apnea---------- Yes No
Diabetes---------- Yes No
Hepatitis, jaundice or liver disease---------- Yes No
If yes to Hepatitis which type_____**Diagnosed on**_____
Inflammatory rheumatism (painful swollen joints)---------- Yes No
Stomach ulcers---------- Yes No
Kidney trouble---------- Yes No
Venereal disease---------- Yes No
Glaucoma---------- Yes No
Have you had abnormal bleeding or serious problems associated with previous extraction, surgery or trauma Yes No
Do you have any blood disorder such as anemia or sickle cell disease---------- Yes No
Have you ever received chemo therapy or radiation therapy---------- Yes No
Have you had a mastectomy---------- Yes No

ARE YOU TAKING ANY OF THE FOLLOWING:

Anticoagulants (blood thinners)---------- Yes No
Recreational drugs---------- Yes No
Antibiotics or sulfa drugs---------- Yes No
Medicine for high blood pressure---------- Yes No
Steroids (now or in the last two years)---------- Yes No
Tranquilizers or sleeping aids---------- Yes No
Antihistamines---------- Yes No
Aspirin---------- Yes No
Insulin, Tolbutamide (orinase) or similar drug---------- Yes No
Digitalis or drugs for heart trouble---------- Yes No
Nitroglycerin (tablets or patch)---------- Yes No
Drugs to treat Osteoporosis/Osteopenia or to strengthen bone---------- Yes No

OTHER INFORMATION:

Have you or any member of your immediate family had any serious problems associated with general anesthesia or sedation---------- Yes No
Are you or could you be pregnant or are you nursing---------- Yes No
Do you drink alcohol or smoke daily---------- Yes No
Are you immunnosuppressed---------- Yes No
Do you or anyone in your family have any disease, condition, disability, or problem not listed above that you think I should know about---------- Yes No
If so, what_____

Please describe in your own words the reason for your visit_____

_____

Signature_____Date_____
Adult Patient or Legal Guardian