l. Hepatitis, jaundice or liver disease ..... Yes No
m. Arthritis or inflammatory rheumatism ..... Yes No
n. Artificial or replacement joints, prosthetic ..... Yes No
o. Digestive system—Ulcers or stomach disorders (colitis) ..... Yes No
p. Kidney trouble ..... Yes No
q. Tuberculosis ..... Yes No
r. Persistent cough or cough up blood ..... Yes No
s. Immune System disorders (including AIDS, HIV, ARC) ..... Yes No
t. Venereal disease ..... Yes No
u. Other _____

8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ..... Yes No
   a. Do you bruise easily ..... Yes No
   b. Have you ever required a blood transfusion ..... Yes No
   If so, explain the circumstances & when _____
9. Have you ever tested positive for the AIDS virus? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? ..... Yes No
12. Are you taking any of the following:
   a. Antibiotics or sulfa drugs ..... Yes No
   b. Anticoagulants (blood thinners) ..... Yes No
   c. Medicine for high blood pressure ..... Yes No
   d. Cortisone (steroids) ..... Yes No
   e. Tranquilizers ..... Yes No
   f. Antihistamines ..... Yes No
   g. Aspirin ..... Yes No
   h. Insulin, tolbutamide (Orinase) or similar drug for diabetes ..... Yes No
   i. Digitalis or drugs for heart trouble ..... Yes No
   j. Nitroglycerin ..... Yes No
   k. Other medications ..... Yes No
   l. If "Yes" to any of the above, state drug name, dosage and frequency _____
13. Are you allergic or have you reacted adversely to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Sulfa drugs ..... Yes No
   d. Barbiturates, sedatives, or sleeping pills ..... Yes No
   e. Aspirin ..... Yes No
   f. Iodine ..... Yes No
   g. Codeine or other narcotics ..... Yes No
   h. Other _____
14. Do you use any tobacco products ..... Yes No
   If so, how much per day and what _____
15. Do you use any alcohol products ..... Yes No
   If so, how much per day/week/month and what _____
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) ..... Yes No
   If so, how much per day and what _____
17. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
   If so, explain _____
   _____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation ..... Yes No
19. Are you wearing contact lenses ..... Yes No
20. Are you experiencing stress or pressure in your work or at home ..... Yes No

WOMEN

20. Are you pregnant ..... Yes No
21. Do you have PMS or problems associated with your menstrual period ..... Yes No
22. Are you taking birth control or hormone therapy ..... Yes No

Remarks:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient Date Signature of Dentist Date