

Patient History

Do you smoke?

Patient Name

Each question must have an answer. Circle yes or no; or write in answers where appropriate. A. General Information E. Genitourinary System Vital Signs (FOR OFFICE USE ONLY) Do you or have you had: Date BP HR Yes No WT Kidney Disease? Yes No Swollen Ankles? 1 Difficulty in or Frequent Urination? Yes No Yes Blood in your Urine? No Other: F. Gastrointestinal System Has there been any change in your general health Yes No Do you or have you had: in the past year? No Yes No Have you had any serious illness or operations? Yes Stomach or Intestinal Trouble? Have you been hospitalized within the past two (2) Indigestion, Diarrhea, Vomiting, Yes No Yes No or Constipation? years? Any recent unexplained gain or loss of weight? Yes No Appetite Problem? Yes No Yes No Hepititis or Jaundice? * If under the care of a physician, give: Yes No Name: iver Disease? Yes No Address: Ulcers? Phone Number: Other: B. Cardiovascular System G. Endocrine System Do you or have you had: Do you or have you had: Yes No Yes No High Blood Pressure? Diabetes? Yes No Yes No Low Blood Pressure? a. Do you frequently have to urinate? Yes No Yes No Heart Attack? b. Are you thirsty much of the time? No Yes Yes No Heart Murmur(congenital heart disease)? c. Is your mouth dry? Yes No Yes No Heart Surgery (bypass, valve)? Thyroid Problem? Yes No Yes No Shortness of breath? Parathyroid Problem? Yes Chest Pain Upon Exertion (Angina)? Yes No No Hormone Therapy? No Swollen Ankles? Yes Other: **Rheumatic Heart Disease or Fever?** Yes No H. Bones and Joints A Stroke? Yes No Do you or have you had: Yes No Yes No A Pacemaker? Arthritis? Yes Inflammatory Rheumatism? No Other: C. Nervous System Yes No Joint Replacement? Do you or have you had: Yes No Back or Neck Injury? No Nervous breakdown/psychotherapy? Yes Epilepsy or Convulsions? Yes No I. Blood - Lymphatic Yes No Do you or have you had: Neuritis, Neuralgia, or Numbness? Yes No Yes No Fainting Spells or Seizures? * Blood Disorder or Anemia? Abnormal Bleeding with Previous Extractions or Other: Yes No Surgery? Yes D. Respiratory System No Transfusions? Do you or have you had: Yes No Bruise Easily? No Yes No Yes Any respiratory Disease? Swollen Lymph Nodes (glands)? Yes No Tuberculosis? Other: Yes No J. Infectious Disease Sinus Trouble? No Yes Do you or have you had: Hay Fever? Yes No Pneumonia? Yes No * Hepatitis: Type A, B or other? No Yes Yes AIDS, ARC, HIV, ANTI-HIV? No Asthma or Emphysema? Yes Syphillis, Gonorrhea, Herpes? No Chronic cough, sore throat, or coughing up blood? Yes No Yes No Acute Pharyngitis (oral or strep) Childhood Diseases: Chicken Pox, Rubella, Did you smoke? Yes No Mumps, Rubeola? Yes No

Yes

No

Are you or have you been an IV drug user?

Yes

No

Centure patients go to Denture History Are you have you had?					Other:
Are you having dental pain or discomfort at this time? Are you having dental pain or discomfort at this time? Prequent Headaches? Yes No Dizzines? Yes No Diz					O. Dental History
time?	K. Head, Eyes				(Denture patients go to Denture History)
Prequent Headaches? Yes No Prequent toothaches? Yes No Prequent toothaches? Yes No Prequent toothaches? Yes No Predominate (upon disease?	Oo you or hav	e you had?			time? Yes No
	Head or Jaw Injυ	ıry?	Ye	s N	Do you or have you had:
Ves No Orthodontic Treatment? Ves No Orthodontic Treatment methodontic Treatment Treatment methodontic Treatment met	requent Headach	nes?	Ye		. request to the desired in
Nose Bleeds? Yes No	Dizziness?		Ye	s N	Periodontal (gum) disease? Yes No
No. Seed S	/ision Problems?	1	Ye	s N	Orthodontic Treatment? Yes No
Authoritics or Sulfa Drugs? Antibiotics or Sulfa Drugs? Yes No Cordisone (steroids)? Yes No Antibiotics or Sulfa Drugs? Yes No Cordisone (steroids)? Yes No Insulin, Ornalse, or Similar Medication? Yes No Chemically Dependent (drugs or alcohol)? Yes No Chemically Dependent (drugs or alcohol)? M. Allergies Are you Allergic or had a Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Barbiturates, Sleeping pills? Yes No Codeine or other Narcotics? Yes No Codeine o	learing Problems	i?	Ye	s N	Difficulty in Opening or Closing your Jaw? Yes No
Chronic Sore Throat? Altered Taste Perceptions? Yes No Doyou Ward Contact Lenses? Yes No Are you taking any of the following? Antibiotics or Sulfa Drugs? Antibiotics or Sulfa Drugs? Yes No High Blood Pressure Medication? Yes No Corrisone (steroids)? Yes No Aspirin? Yes No Aspirin? Yes No Chemically Dependent (drugs or alcohol)? Yes No Chemically Dependent (drugs or alcohol)? Yes No Sulfa Drugs? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Reaction to: Local Anesthetic (Novocaine, etc.)? Yes No Capital Experience in a dental office? Yes No Capital Experiences in General been? Children Only: Local Anesthetic (Novocaine, etc.)? Yes No Capital Experience in a dental office? Yes No Capital Experiences in General been? Children Only: Local Anesthetic (Novocaine, etc.)? Yes No Capital Experience	Nose Bleeds?		Ye	s N	Grinding or Clenching your Teeth? Yes No
halitosis? Yes No Altered Taste Perceptions? Yes No Ory Mouth? Yes No Do you Wear Contact Lenses? L. Medications Are you taking any of the following? Antibiotics or Sulfa Drugs? Antibiotics or Sulfa Drugs? Cordisone (steroids)? Yes No Aspirin? Yes No Chemically Dependent (drugs or alcohol)? Yes No Chemically Dependent (drugs or alcohol)? M. Allergies Are you Allergic or had a Reaction to: L. Load Anesthetic (Novocaine, etc.)? Yes No Sulfa Drugs? Yes No Sulfa Drugs? Yes No Sulfa Drugs? Yes No Sulfa Drugs? Yes No Codeine or other Narcotics? Yes No Code Sulfa Drugs? Yes No Codeine or other Narcotics? Yes No Codeine or other Narcotics? Yes No Codeine or other Narcotics? Yes No Code Sulfa Drugs? Yes No Code Sulfa Drugs? Yes No Codeine or other Narcotics? Yes No Codeine or other Narcotics? Yes No Code Sulfa Drugs? Yes No Codeine or other Narcotics? Yes No Codeine or other Narcotics? Yes No Code Sulfa Drugs? Yes No Code Sulfa Drugs Yes No Code Sulfa	Nasal Obstruction	ns?	Ye	s N	Chronic Facial Pain? Yes No
Alticosis? Ves No Ory Mouth? Ves No Ory Mouth? Ves No Ory Wear Contact Lenses? L. Medications Are you taking any of the following? Antibotics or Sulfa Drugs? Anticoagulants (blood thinners)? Ves No Cordisone (steroids)? Ves No Aspirin? Ves No Object having Dental Treatment make you nervous? Antibotics or Sulfa Drugs? Ves No Chemically Dependent (drugs or alcohol)? Ves No M. Allergies Are you Allergic or had a Reaction to: Local Anesthetic (Novocaine, etc.)? Sulfa Drugs? Ves No Reprint? Ves No Reprinting? Ves No Reprinting? Ves No M. Allergies Are you Allergic or had a Reaction to: Local Anesthetic (Novocaine, etc.)? Ves No Reprinting? Ves No Reprinting? Ves No Reprinting? Ves No Reprinting? Ves No M. Allergies Are you Allergic or had a Reaction to: Local Anesthetic (Novocaine, etc.)? Ves No Reprinting? Ves No Reprinting Redication? Ves No Reprinting Redic	Chronic Sore Thre	pat?	Ye	s N	Do you Brush Daily? Yes No
Altered Taste Perceptions? Yes No Dry Mouth? Yes No Do you wart to keep your Teeth? Yes No Does having Dental Treatment make you nervous? Yes No Have you had a bad experience in a dental office? Yes No Have you had a bad experience in a dental office? Yes No Anticoagulants (blood thinners)? Yes No High Blood Pressure Medication? Yes No Cortisone (steroids)? Yes No Antihistimines? Yes No Antihistimines? Yes No Insulin, Ornaise, or Similar Medication? Yes No No No Nother Medications? Yes No Chemically Dependent (drugs or alcohol)? Yes No Chemically Dependent (drugs or alcohol)? Yes No Penicillin or other Antibiotics? Yes No Penicillin or other Antibiotics? Yes No Salifa Drugs? Yes No Penicillin or other Antibiotics? Yes No Codeine or other Narcotics? Yes No	Halitosis?		Ye	s N	
Dry Mouth? Yes No Do you Wear Contact Lenses? Description: L. Medications Are you taking any of the following? Antibolagulants (blood thinners)? Yes No Cortisone (steroids)? Yes No Anticoagulants (blood thinners)? Yes No Cortisone (steroids)? Yes No Antipulizers? Antibulin, Ornaise, or Similar Medication? Poly Insulin, Ornaise, or Similar Medication? Poly Insulin, Ornaise, or Similar Medication? Yes No Cothemically Dependent (drugs or alcohol)? Yes No M. Allergies Are you Allergic or had a Reaction to: Local Anesthetic (Novocaine, etc.)? Penicillin or other Antibiotics? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Cadeline or other Narcotics? Yes No Caspirin? Yes No Casp		centions?			Do you . 1000 Dumy.
Do you Wear Contact Lenses? L. Medications Are you taking any of the following? Antibiotics or Sulfa Drugs? Antibiotics or Sulfa Drugs? High Blood Pressure Medication? Yes No Cortisone (steroids)? Tranquilizers? Yes No Aspirin? Yes No Insulin, Ornaise, or Similar Medication? Ves No Chemically Dependent (drugs or alcohol)? Ves No Chemically Dependent (drugs or alcohol)? Ves No M. Allergies Are you taking any of the following? Are you allergic or had a Reaction to: Local Anesthetic (Novocaine, etc.)? Ves No Penicillin or other Antibiotics? Ves No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Rapirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes No Penicillin or other Antibiotics? Yes No Caspirin? Yes		осриона і			Does having Dental Treatment make you
Have your Dental Experiences in General been? (please circle one)	ory mount				
Chemically Dependent (drugs or alcohol)? * Note of the Medication? * An eyou taking any of the following? * Antibiotics or Sulfa Drugs? * No * High Blood Pressure Medication? * Yes No * Cortisone (steroids)? * Tranquilizers? * Yes No * Antihistimines? * Yes No * Antihistimines? * Yes No * Antihistimines? * Yes No * Insulin, Ornalse, or Similar Medication? * Pes No * Chemically Dependent (drugs or alcohol)? * No * Other Medications? * Yes No * Other Medication? * Yes No * Local Anesthetic (Novocaine, etc.)? * Pes Insulin or other Antibiotics? * Yes No * Barbiturates, Sleeping pills? * Yes No * Codeine or other Narcotics?	Do you Wear Con	tact Lenses?	Ye	s N	
Are you taking any of the following? Antibiotics or Sulfa Drugs? Yes No Cortisone (steroids)? Yes No Cortisone (steroids)? Yes No Tranquilizers? Yes No Aspirin? Yes No Denture History: a. Do you think you need dentures? Denture History: a. Do you think you need dentures? Yes No b. How long have you worn Dentures? C. How old are your present Dentures? P. Women Only Are you Pregnant? Yes No Chemically Dependent (drugs or alcohol)? Yes No M. Allergies Are you Allergic or had a Reaction to: **Local Anesthetic (Novocaine, etc.)? Yes No Penicillin or other Antibiotics? Yes No Sulfa Drugs? Yes No Aspirin? Yes No Chodeine or other Narcotics? Yes No Codeine or other Narcotics? Yes No Children Only: a. Flouride (dietary Hx)? b. Good Oral Habits? Yes No C. Birth History Normal? Pes No Denture History: a. Plouride (dietary Hx)? S. Good Oral Habits? Yes No Denture History: a. Pount History: a. Pount with Istory uneed dentures? Yes No Denture History: a. Pount Plistory: b. How long have you worn Dentures? C. How old are your present Dentures? P. Women Only *Are you Pregnant? Yes No Menstrual Problems? Yes No Other: Please list current medications: Please list current medications: Please list current medications:	Other:				
Antibiotics or Sulfa Drugs? Anticoagulants (blood thinners)? Anticoagulants (blood thinners)? Yes No High Blood Pressure Medication? Yes No Cortisone (steroids)? Yes No Antihistimines? Antihistimines? Yes No Aspirin? Yes No Chemically Dependent (drugs or alcohol)? Yes No M. Allergies Are you Allergic or had a Reaction to: Yes No Sulfa Drugs? Yes No Sulfa Drugs? Yes No Chemically Dependent (Novocaine, etc.)? Yes No Sulfa Drugs? Yes No Sulfa Drugs? Yes No Penicillin or other Antibiotics? Yes No Sulfa Drugs? Yes No Please list current medications: Yes No Please list current medications:			ng?		GOOD AVERAGE POOR
Anticoagulants (blood thinners)? High Blood Pressure Medication? Yes No Cortisone (steroids)? Tranquilizers? Antihistimines? Aspirin? Denture History Normal? Yes No Commodification? Yes No Penicillin or other Antibiotics? Yes No Commodification? Yes No Commodification? Yes No Penicillin or other Antibiotics? Yes No Commodification to: P. Women Only *Are you reganant? Yes No Are you taking Birth Control Pills? Yes No Commodification to: *Are you taking Birth Control Pills? Yes No Commodification to: *Are you taking Birth Control Pills? *Are you been through Menopause? Yes No Commodification to: *Are you taking Birth Control Pills? *Are you been through Menopause? Yes No Commodification to: *Are you taking Birth Control Pills? *Are you taking Birth Control Pills? *Are you been through Menopause? *Are you taking Birth Control Pills? *A				- 1	Children Only
High Blood Pressure Medication? Yes No					
Cortisone (steroids)? Yes No Tranquilizers? Yes No Antihistimines? Yes No Aspirin? Yes No Insulin, Ornaise, or Similar Medication? Yes No Digitalis or other Heart Medication? Yes No Chemotherapy? Yes No Chemically Dependent (drugs or alcohol)? Yes No Posicial Anesthetic (Novocaine, etc.)? Yes No Penicillin or other Antibiotics? Yes No Sarbiturates, Sleeping pills? Yes No Codeine or other Narcotics? Yes No Codeine or o		•		_	
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Aspirin? Yes No	Tranquilizers?		Ye	s N	
Insulin, Ornaise, or Similar Medication? Digitalis or other Heart Medication? Ves No No Nother Medication? Chemotherapy? Chemotherapy? Chemically Dependent (drugs or alcohol)? Other Medications? Are you Allergies Are you Allergic or had a Reaction to: Local Anesthetic (Novocaine, etc.)? Penicillin or other Antibiotics? Yes No Barbiturates, Sleeping pills? Yes No Solidane? Yes No P. Women Only *Are you Pregnant? Do you or have you had: Menstrual Problems? Breast Cancer/Tumor? Yes No Have you been through Menopause? Yes No Other: Please list current medications: Please list current medications: Please list current medications: Codeine or other Narcotics? Yes No Yes No	Antihistimines?		Ye	s N	a. Do you think you need dentures? Yes No
* Insulin, Ornaise, or Similar Medication? * Digitalis or other Heart Medication? * Digitalis or other Heart Medication? * No * No * Chemotherapy? * Other Medications? * Other Medications? * Chemotherapy? * Other Medications? * Other Medications? * Are you Pregnant? * Yes No * Other Medications? * Are you or have you had: * Do you or have you had: * Menstrual Problems? * Breast Cancer/Tumor? * Are you taking Birth Control Pills? * Are you been through Menopause? * Yes No * Sulfa Drugs? * Sulfa Drugs? * Aspirin? * Aspirin? * Jes No * Codeine or other Narcotics? * No * Other: * Codeine or other Narcotics? * No * Other: * Codeine or other Narcotics? * No * Other: * Codeine or other Narcotics? * No * Other: * Codeine or other Narcotics? * No * Other: * Codeine or other Narcotics? * No * Other: * Codeine or other Narcotics? * No * Other: * Codeine or other Narcotics? * Other: * Other: * Are you pregnant? * Are you Pregnant? * Are you Pregnant? * Are you or have you had: * Menstrual Problems? * Are you taking Birth Control Pills? * Are you been through Menopause? * Other: * Please list current medications: * Please list current medications: * Other: * Other: * Other: * Other: * Are you or have you pregnant? * Are you or have you had: * Other you had: * Are you or have you had: * Are you been through Menopause? * Are you had: * Are you been through Menopause? * Are you had: * Are you been through Menopause? * Are you had: * Are you been through Menopause? * Are you had:	Aspirin?		Ye	s N	b. How long have you worn Dentures?
* Digitalis or other Heart Medication? Yes No * Nitroglycerin? Yes No Chemotherapy? * Chemotherapy? * Chemically Dependent (drugs or alcohol)? * Other Medications? * M. Allergies Are you Allergic or had a Reaction to: * Local Anesthetic (Novocaine, etc.)? * Penicillin or other Antibiotics? Yes No * Sulfa Drugs? * Sulfa Drugs? * Sulfa Drugs? * Are you allergic or had a Reaction to: * Sulfa Drugs? * Yes No * Barbiturates, Sleeping pills? Yes No * Codeine or other Narcotics? Yes No * Codeine or other Narcotics? Yes No * Codeine or other Narcotics?	•	or Similar Medication?	Ye	s N	
* Are you Pregnant? Yes No * Chemotherapy? * Chemically Dependent (drugs or alcohol)? * Other Medications? * M. Allergies Are you Allergic or had a Reaction to: * Local Anesthetic (Novocaine, etc.)? * Penicillin or other Antibiotics? * Yes No * Barbiturates, Sleeping pills? * Aspirin? * Yes No * Codeine or other Narcotics? * Are you Pregnant? * Are you had: * Menstrual Problems? * Are you taking Birth Control Pills? * Are you been through Menopause? Other: * Please list current medications: * Please list current medications: * Other:					
Chemotherapy? Chemically Dependent (drugs or alcohol)? Chemically Dependent (drugs or alcohol)? Other Medications? Menstrual Problems? Breast Cancer/Tumor? Yes No Are you Allergic or had a Reaction to: Local Anesthetic (Novocaine, etc.)? Penicillin or other Antibiotics? Yes No Penicillin or other Antibiotics? Yes No Barbiturates, Sleeping pills? Yes No I dodine? Yes No Codeine or other Narcotics? Yes No Yes No Codeine or other Narcotics? Yes No Codeine or other Narcotics? Yes No				_	
Chemically Dependent (drugs or alcohol)? Cother Medications? M. Allergies Are you Allergic or had a Reaction to: Local Anesthetic (Novocaine, etc.)? Penicillin or other Antibiotics? Yes No Barbiturates, Sleeping pills? Aspirin? Codeine or other Narcotics? Yes No Yes No Yes No Yes No Please list current medications: Please list current medications: Please No Please list current medications: Please No Please list current medications: Please No Please					
M. Allergies M. Allergies Are you Allergic or had a Reaction to: Local Anesthetic (Novocaine, etc.)? Penicillin or other Antibiotics? Sulfa Drugs? Barbiturates, Sleeping pills? Yes No Aspirin? Yes No Codeine or other Narcotics? Yes No Menstrual Problems? Breast Cancer/Tumor? Are you taking Birth Control Pills? Have you been through Menopause? Other: Please list current medications: Please list current medications: Yes No Yes No Yes No Yes No Yes No		andont (dwise as also be			— Do you or have you had:
M. Allergies Are you Allergic or had a Reaction to: * Local Anesthetic (Novocaine, etc.)? * Penicillin or other Antibiotics? * Sulfa Drugs? * Barbiturates, Sleeping pills? * Aspirin? * Please list current medications: * Please list current medications: * Codeine or other Narcotics?		•	-,-		
* Are you Allergic or had a Reaction to: * Local Anesthetic (Novocaine, etc.)? * Penicillin or other Antibiotics? * Sulfa Drugs? * Barbiturates, Sleeping pills? * Aspirin? * Codeine or other Narcotics? * Are you taking Birth Control Pills? * Ar	Other Medication		Ye	s N	
* Local Anesthetic (Novocaine, etc.)? * Local Anesthetic (Novocaine, etc.)? * Penicillin or other Antibiotics? * Sulfa Drugs? * Sulfa Drugs? * Barbiturates, Sleeping pills? * Aspirin? * Aspirin? * Iodine? * Codeine or other Narcotics? Yes No * Codeine or other Narcotics? Yes No					
Penicillin or other Antibiotics? Yes No Sulfa Drugs? Barbiturates, Sleeping pills? Yes No Aspirin? Yes No I lodine? Yes No Codeine or other Narcotics? Yes No Yes No Yes No Yes No Yes No Yes No	Are you Allerg	ic or had a Reaction			7 2 3 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
Sulfa Drugs? Yes No Barbiturates, Sleeping pills? Yes No Aspirin? Yes No Blodine? Yes No Codeine or other Narcotics? Yes No	Local Anesthetic	(Novocaine, etc.)?	Ye		Have you been through Menopause? Yes No
Barbiturates, Sleeping pills? Yes No Aspirin? Yes No Iodine? Yes No Codeine or other Narcotics? Yes No	Penicillin or other	er Antibiotics?	Ye	s N	Other:
* Barbiturates, Sleeping pills? * Aspirin? * Iodine? * Codeine or other Narcotics? Yes No * Codeine or other Narcotics? Yes No	Sulfa Drugs?		Ye	s N	
* Aspirin? Yes No * Iodine? Yes No * Codeine or other Narcotics? Yes No		eping pills?		_	Please list current medications:
Yes No Codeine or other Narcotics? Yes No	· · · · · · · · · · · · · · · · · · ·	oping pina:			
*Codeine or other Narcotics? Yes No					⊣
		r Naraatica?			-
metals (rings, earrings, etc.)?				_	
Vos No					
			Ye	S N	-
			exposes		7
you to X-Rays or other ionizing radiation? Yes No	you to X-Rays or other ionizing radiation?		? Ye	s_N	
				s N	
,	N. F Are you employed you to X-Rays or d	Radiation History I in any situation which other ionizing radiation	exposes ? Ye	es N	
To the best of my Knowledge, all of the preceding answers are true and correct. If I ever have any changes in health o if my medications change, I will inform Aspen Leaf Dental personnel at the time of my next appointment without foil				n Äspe	
without fail.				ness Sign	ure Patient, Parent or Guardian Signature
	 Date Den	tist Signature	******		
	Date Den	itist Signature		tory/Ph	ical Evaluation Update:

 Yes / No	Yes / No	Yes / No
 Yes / No	Yes / No	Yes / No