HEALTH HISTORY

Are you had excessive bleeding requiring special treatment? Have you had any adverse drug reaction? Explain Do you smoke? ARE YOU ALLERGIC TO: Local anesthetics (for example - novocaine or lidocaine)? Penicillin or other antibiotic? Sulfa drugs? Barbiturates, sedatives, sleeping pills? Codeline? Aspirin? Other drugs? If yes, please list Do you have any other allergies? HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS: Rheumatic Fever? Heart disease or heart murmur? Any heart prosthesis (pacemaker, heart valves)? Stroke? Diabetes? High or low blood pressure? Liver or kidney disorders (tuberculosis, asthma, hay fever)? Sinus problems? Arthritis? Arthritis? Arthritis? Arthritis? Arthritis? Arthritis Pherous disorders or psychiatric care? Epilepsy? Fainting spells or seizures? Stomach ulcers? Cancer? Alcoholism or drug addiction? Sexually transmitted diseases (Syphilis, Gonorrhea, Herpes)? AIDS or other immunosuppressive disorders? Have you ever had a blood transfusion? If so, when Do you have any disease, condition, or problem not listed above that we should know about? If yes, et also list the names of individuals you permit us to discuss your dental treatment: WOMEN Are you taking birth control pills or other hormonal therapy?	?
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Osteopenia or Osteoporosis?	

Patient's Signature_____

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_Date____