Other Information

Date of Last Dental Visit: _____

ANSWER YES OR NO AND GIVE OTHER INFORMATION WHERE APPROPRIATE:

Are you presently under the care of a physician? _____

If yes, for what reason? _____

Are you allergic to any medications? _____

If yes, please list them. _____ _____

Have you been hospitalized in the last 5 years? _____

If yes, please give reason and dates _____

Have you had blood transfusions-if so, when _____

Do you smoke cigarettes? _____

Do you consume alcohol on a daily basis? _____

Is your blood pressure normal,high or low? (circle one) _____

Do you have hypertension? _____

Have you ever had a stroke? _____

Do you have any congenital Heart Defects? _____

Do you have heart disease? _____

Have you ever had rheumatic fever? _____

Been diagnosed with a heart murmur or mitral valve prolapse? Circle which _____

Do you have thyroid problems? _____

Have you ever had tuberculosis or lung disease? When? _____

Have you ever been diagnosed with diabetes? When? _____

Have you ever suffered from epilepsy or had seizures? When? _____

Have you been anemic in the last 5 years? _____

Have you ever been diagnosed with cancer or leukemia.. what kind/when? _____