Do you have any prosthetic valves or joints? What kind? _____

Have you ever been diagnosed with jaundice? When?

Do you have a persistent cough? For how long?

Do you have prolonged bleeding problems?

Sexually Transmitted Diseases?

Do you have skin disease?

Are you HIV Positive? Do you have Aids?

Do you have unexplained fevers?

Do you suffer from prolonged sore throats?

Do you have enlarged lymph nodes?

Night Sweats?

Persistent Diarrhea?

Bluish-Reddish Lesions?

Do you suffer from chronic fatigue?

Have you ever had hepatitis? If so, when?

Are you pregnant? Number of months _____

Have you been treated by a dentist in the last 12 months?

Do your gums bleed while brushing and/or flossing?

Any serious problems with previous dental treatment? Add anything else you think is important.

List Medications Presently Taking _____

Pharmacy Name _Phone Number _____

IN EMERGENCY, NOTIFY: _____

PHONE: _____

PATIENT/GUARDIAN SIGNATURE _____DATE _____