

I. Check Appropriate Answers: (Leave blank if you do not understand the question)

Yes	No			
<input type="checkbox"/>	<input type="checkbox"/>	1.	Is your general health good? _____	
<input type="checkbox"/>	<input type="checkbox"/>	2.	Has there been a change in your health within the last year? _____	
<input type="checkbox"/>	<input type="checkbox"/>	3.	Have you been hospitalized or had a serious illness in the last three years? _____ Please explain _____	
<input type="checkbox"/>	<input type="checkbox"/>	4.	Are you being treated by a Physician now? _____ Please explain _____ Date of last general exam ____/____/____ Date of last Dental exam ____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	5.	If you answer yes to 4, name of your Physician _____ Phone Number (_____) _____	
<input type="checkbox"/>	<input type="checkbox"/>	6.	Have you had problems with prior dental treatment? Please explain _____	
<input type="checkbox"/>	<input type="checkbox"/>	7.	Are you in pain now? Explain _____	

II. Have You Experienced:

Yes	No			Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	8.	Chest pain (angina)?	<input type="checkbox"/>	<input type="checkbox"/>	19.	Dizziness?
<input type="checkbox"/>	<input type="checkbox"/>	9.	Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	20.	ringing in the ears?
<input type="checkbox"/>	<input type="checkbox"/>	10.	Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	21.	Headaches?
<input type="checkbox"/>	<input type="checkbox"/>	11.	Recent weight loss, fever, night sweat?	<input type="checkbox"/>	<input type="checkbox"/>	22.	Fainting spells?
<input type="checkbox"/>	<input type="checkbox"/>	12.	Persistent cough, Coughing up blood?	<input type="checkbox"/>	<input type="checkbox"/>	23.	Blurred vision?
<input type="checkbox"/>	<input type="checkbox"/>	13.	Bleeding problems, bruising easily?	<input type="checkbox"/>	<input type="checkbox"/>	24.	Seizures?
<input type="checkbox"/>	<input type="checkbox"/>	14.	Sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>	25.	Excessive thirst?
<input type="checkbox"/>	<input type="checkbox"/>	15.	Difficulty swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Frequent urination?
<input type="checkbox"/>	<input type="checkbox"/>	16.	Diarrhea, constipation, blood in stools?	<input type="checkbox"/>	<input type="checkbox"/>	27.	Dry mouth?
<input type="checkbox"/>	<input type="checkbox"/>	17.	Frequent vomiting, nausea?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Jaundice?
<input type="checkbox"/>	<input type="checkbox"/>	18.	Difficulty urinating, blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>	29.	Joint pain, stiffness?

III. Do you Have Or Have You Had:

Yes	No			Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	30.	Heart disease? Explain _____	<input type="checkbox"/>	<input type="checkbox"/>	41.	AIDS or ARC?
<input type="checkbox"/>	<input type="checkbox"/>	31.	Heart attack? Explain _____	<input type="checkbox"/>	<input type="checkbox"/>	42.	HIV positive
<input type="checkbox"/>	<input type="checkbox"/>	32.	Heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	43.	VD (syphilis or gonorrhea)?
<input type="checkbox"/>	<input type="checkbox"/>	33.	High Blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	44.	Herpes?
<input type="checkbox"/>	<input type="checkbox"/>	34.	Stroke, hardening of arteries?	<input type="checkbox"/>	<input type="checkbox"/>	45.	Skin diseases?
<input type="checkbox"/>	<input type="checkbox"/>	35.	Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	46.	Eye disease?
<input type="checkbox"/>	<input type="checkbox"/>	36.	TB, emphysema, other lung diseases?	<input type="checkbox"/>	<input type="checkbox"/>	47.	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	37.	Hepatitis, other liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	48.	Arthritis, rheumatism?
<input type="checkbox"/>	<input type="checkbox"/>	38.	Stomach problems, ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	49.	Kidney, bladder disease?
<input type="checkbox"/>	<input type="checkbox"/>	39.	Allergies? _____	<input type="checkbox"/>	<input type="checkbox"/>	50.	Thyroid, adrenal disease?
<input type="checkbox"/>	<input type="checkbox"/>	40.	Allergies to Latex?	<input type="checkbox"/>	<input type="checkbox"/>	51.	Diabetes?

IV. Do You Have Or Have You Had:

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	52.	Tumors, cancer?
<input type="checkbox"/>	<input type="checkbox"/>	53.	Radiation treatments?
<input type="checkbox"/>	<input type="checkbox"/>	54.	Chemotherapy?
<input type="checkbox"/>	<input type="checkbox"/>	55.	Prosthetic heart valve?
<input type="checkbox"/>	<input type="checkbox"/>	56.	Artificial joint?
<input type="checkbox"/>	<input type="checkbox"/>	57.	Contact lens ?
<input type="checkbox"/>	<input type="checkbox"/>	58.	Blood transfusions?
<input type="checkbox"/>	<input type="checkbox"/>	59.	Surgeries?
<input type="checkbox"/>	<input type="checkbox"/>	60.	Pacemaker?
<input type="checkbox"/>	<input type="checkbox"/>	61.	Psychiatric care?

V. Are You Taking:

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	62.	Recreational drugs? (Addiction)
<input type="checkbox"/>	<input type="checkbox"/>	63.	Tobacco in any form?
<input type="checkbox"/>	<input type="checkbox"/>	64.	Alcohol?
<input type="checkbox"/>	<input type="checkbox"/>	65.	Medications , (including Aspirin)?
<input type="checkbox"/>	<input type="checkbox"/>	66.	Diet pills, like Phen-Phen

Please list: _____

VI. Women Only:

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	67.	Are you or could you be pregnant or nursing?
<input type="checkbox"/>	<input type="checkbox"/>	68.	Taking birth control pills?

VII. All Patients:

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	69.	Do you have had any other diseases or medical problems <u>NOT listed on this form</u> ? Please explain _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr. Luis Paniagua of any change in my health and or medication.

Date ____/____/____ Patient's Signature _____ Doctor _____

RECALL REVIEW

1. Date ____/____/____	Medical Changes _____	Patient's Signature _____	Doctor _____
2. Date ____/____/____	Medical Changes _____	Patient's Signature _____	Doctor _____
3. Date ____/____/____	Medical Changes _____	Patient's Signature _____	Doctor _____