Are you under a physicians care now? __Yes __No If Yes_____
Have you ever been hospitilized or had a major operation? __Yes __No If Yes_____
Have you ever had a serious head or neck injury? __Yes __No If Yes_____
Are you taking any medications, pills, or drugs? __Yes __No If Yes_____
Do you use controlled substances? __Yes __No If Yes_____
Do you take, or have you taken, Phen-Fen or Redux? __Yes __No If Yes_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? __Yes __No If Yes_____
Have you received the HPV vaccine? __Yes __No
Do you suffer from acid reflux/GERD? __Yes __No
Do you (or has anyone ever told you that you) snore at night? __Yes __No
Do you feel well rested? __Yes __No
Are you on a special diet? __Yes __No
Do you use tobacco? __Yes __No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acryllic Metal Latex Sulfa Drugs Local Ansthetics

Acetaminophen Iodine Amoxicillin Clindamycin Erytho Other: _____

WOMEN: Are you…

Pregnant? Trying to get pregnant? Nursing? Take oral contraceptives?

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Fainting Spells/ Dizziness	Yes	No	Pain in Jaw Joints	Yes	No
Alzheimer's Disease	Yes	No	Frequent Cough	Yes	No	Parathyroid Disease	Yes	No
Anaphylaxis	Yes	No	Frequent Diarrhea	Yes	No	Venereal Disease	Yes	No
Anemia	Yes	No	Frequent Headaches	Yes	No	Circulatory Problems	Yes	No
Angina	Yes	No	Genital Herpes	Yes	No	Cardiovascular Disease	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Frequent Ear Aches	Yes	No
Artificial Heart Valve	Yes	No	Hay Fever	Yes	No	Convulsions	Yes	No
Artificial Joint	Yes	No	Heart Attack/ Failure	Yes	No	Radiation Treatments	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Recent Weight Loss	Yes	No
Blood Disease	Yes	No	Heart Pacemaker	Yes	No	Renal Dialysis	Yes	No
Blood Transfusion	Yes	No	Psychiatric Care	Yes	No	Rheumatic Fever	Yes	No
Breathing Problems	Yes	No	Immune Deficiency	Yes	No	Rheumatism	Yes	No
Bruise Easily	Yes	No	Back Problems	Yes	No	Scarlet Fever	Yes	No
Cancer	Yes	No	Sleep Apnea	Yes	No	Shingles	Yes	No
Chemotherapy	Yes	No	Teeth Grinding/Clenching	Yes	No	Sickle Cell Disease	Yes	No
Chest Pains	Yes	No	Hemophilia	Yes	No	Sinus Trouble	Yes	No
Cold Sores/ Fever Blisters	Yes	No	Hepatitis A	Yes	No	Spina Bifida	Yes	No
Congenital Heart Disorder	Yes	No	Hepatitis B or C	Yes	No	Stomach/Intestinal Disease	Yes	No
Heart Trouble/Disease	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Gout	Yes	No	High Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Any Type of Implant	Yes	No	High Cholesterol	Yes	No	Thyroid Disease	Yes	No
Neurological Disorder	Yes	No	Hives or Rash	Yes	No	Tonsillitis	Yes	No
Stomach Problems	Yes	No	Hypoglycemia	Yes	No	Tuberculosis	Yes	No
Cortisone Medicine	Yes	No	Irregular Heartbeat	Yes	No	Tumors or Growths	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No	Ulcers	Yes	No
Drug Addiction	Yes	No	Leukemia	Yes	No	Yellow Jaundice	Yes	No
Easily Winded	Yes	No	Liver Disease	Yes	No	Depression/ Anxiety	Yes	No
Emphysema	Yes	No	Low Blood Pressure	Yes	No	Gastrointestinal Disease	Yes	No
Epilepsy or Seizures	Yes	No	Lung Disease	Yes	No	HPV	Yes	No
Excessive Bleeding	Yes	No	Mitral Valve Prolapse	Yes	No	Osteopenia	Yes	No
Excessive Thirst	Yes	No	Osteoporosis	Yes	No			

Have you ever had any serious illness not listed above? _____

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