Health Information:

1. Are you taking any medication now? YES NO

If yes, please list both prescribed and over the counter medications that you take in the space below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Have you received Dental treatment before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Please check any illnesses or conditions you have EVER had

* Allergies to Medicine(s)
* Epilepsy
* Anemia or blood problems
* Any Heart Ailments
* Stroke
* Hepatitis A, B, C
* Thyroid Problems
* High Blood Pressure
* Tuberculosis
* Asthma
* Ulcer
* Cancer or Chemotherapy
* Kidney problems
* Diabetes
* Liver problems
* Use of tobacco, cigarettes, chew

4. Do you have any other health conditions? YES NO

If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Do you have any allergies? If yes, please check all that apply: YES NO

* Penicillin
* Antibiotics
* Anesthetics
* Aspirin
* Foods
* Latex
* Other: \_\_\_\_\_\_\_\_\_\_

7. What do you do to take care of your teeth and gums?

Daily tooth brushing Daily flossing

8. Is your drinking water supply from a bore hole? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_