

Have you ever had Bacterial Endocarditis? Yes No

Do you have a Prosthetic Cardiac Valve? Yes No

Do you have Congenital Heart Disease (excluding Mitral Valve Prolapse)? Yes No

If yes, please be specific: _____

Have you had a cardiac transplant? Yes No

If yes, have you had Valvulitis? Yes No

Heart, Cardiac, or Hypertension Medications you are currently on (Name / Strength / Frequency):

_____ / _____ / _____ X (s) per day Every _____ Hrs _____ / _____ / _____ X (s) per day Every _____ Hrs

_____ / _____ / _____ X (s) per day Every _____ Hrs _____ / _____ / _____ X (s) per day Every _____ Hrs

_____ / _____ / _____ X (s) per day Every _____ Hrs _____ / _____ / _____ X (s) per day Every _____ Hrs

Have you ever experienced chest pain (Angina)? Yes No

Have you had chest pain (Angina) at rest? Yes No

Have you had recent changes in your medications for chest pain (Angina)? Yes No

What medications for chest pain (Angina) are you currently taking (Name / Strength / Frequency)?

_____ / _____ / _____ X (s) per day Every _____ Hrs _____ / _____ / _____ X (s) per day Every _____ Hrs

If you have experienced a heart attack in the past, when were they? _____ / _____ / _____ _____ / _____ / _____

Have you had a coronary stent or a heart bypass in the last (CIRCLE) 6 months? 9 months? 12 months?

Are you currently on Plavix or any other anti-platelet protective medication? Yes No

Do you take a daily aspirin? Yes No If so, Strength / Frequency? _____ / _____ X (s) per day Every _____ Hrs

Are you currently taking any sleep aid medications? Yes No If so, what strengths of the following? _____ mg

Sonata Ambien Ambien CR Lunesta BuSpar Vistaril Rozerem Unisom

Are you currently being treated for Restless Leg Syndrome (RLS)? Yes No If so, which of the following? _____ mg

Lyrica Cymbalta Neurontin

Are you currently taking any antidepressants such as Prozac, Welbutrin, Paxil, and Zoloft? Yes No

If so, please list Name of Medication / Strength / Frequency of use:

_____ / _____ / _____ X (s) per day Every _____ Hrs _____ / _____ / _____ X (s) per day Every _____ Hrs

_____ / _____ / _____ X (s) per day Every _____ Hrs _____ / _____ / _____ X (s) per day Every _____ Hrs

AIDS / HIV Yes No Epilepsy Yes No Respiratory Diseases Yes No

Anemia Yes No Fainting or dizziness Yes No Arthritis, Rheumatism Yes No

Glaucoma Yes No Scarlet Fever Yes No Headaches Yes No

Shortness of Breath Yes No Artificial Joints Yes No Sinus Trouble Yes No

Asthma Yes No Heart Problems Yes No Skin Rash Yes No

Back problems Yes No Hepatitis Type _____ Yes No Special Diet Yes No

Bleeding abnormally Yes No Herpes Yes No Stroke Yes No

High Blood Pressure Yes No Swollen Feet / Ankles Yes No Blood Disease Yes No

Jaundice Yes No Swollen Neck Glands Yes No Cancer Yes No

Jaw Pain Yes No Thyroid Problems Yes No Chemical Dependency Yes No

Kidney Disease Yes No Tonsillitis Yes No Chemotherapy Yes No

Liver Disease Yes No Transfusions (Blood) Yes No Circulatory Problems Yes No

Low Blood Pressure Yes No Tuberculosis Yes No Cortisone Treatments Yes No

Nervous Problems Yes No Cough, persistent Yes No Pacemaker Yes No

Ulcers Yes No Psychiatric Care Yes No Venereal Disease Yes No

Emphysema Yes No Radiation Treatment Yes No Weight Loss (Sudden) Yes No

Have you ever taken any medications collectively referred to as "Fen-Phen"? These include combinations of Lonimin, Adipex, Fastin (Brand name of Phentermine, Pondimine (Fenfluramine) & Redux (dexfenfluramine). Yes No

Do you intake alcohol? Yes No If so, Type / Frequency? _____ / _____ X (s) Per Day Per Week Every _____ Hrs

Do you intake Caffeine? Yes No If so, Type / Frequency? _____ / _____ X (s) Per Day Per Week Every _____ Hrs

Have you had history of a Gastric Bypass (surgery)? Yes No

Have you had any surgeries? Yes No If so, how long ago and what for? _____

Do you wear contact lenses? Yes No Do you have tingling of your fingertips? Yes No

Do you have ringing in the ears? Yes No Do you have postural problems? Yes No

Do you have ear congestion? Yes No Do you have occasional neck pains? Yes No

Do you see or have you seen a Chiropractor or Physical Therapist (Circle One) in the last five years? Yes No

If so, what for _____ and have you ever sustained a motor vehicle accident? Yes No

Have you ever had CAT scans or MRI's? Yes No

Have you ever seen an ENT (Ear Nose and Throat Specialist)? Yes No

Do you have sinus problems? Yes No

Do you consume grapefruit juice, grapefruits, or grapefruit extract? Yes No

Are you taking Tagamet? Yes No If so, how often? _____

Do you take Antacids? Yes No If so, how often? _____

Are you taking any Herbal Supplements / Medicines like St. John's Wort? Yes No
If so, which ones? _____

Are you a Smoker? Yes No How Much Do You Smoke? _____ Pack(s) per Day Week Month

Women:

Are you pregnant or POSSIBLY pregnant at this time? Yes No

If, so what would be the approximate Due Date _____ Are you currently nursing? Yes No

Are you currently taking birth control pills? Yes No If so, what kind? _____

Do you plan or anticipate on being pregnant in the near future? Yes No

List any other Over-the-Counter medications, Vitamins, or other supplements you are taking (Name / Strength / Frequency):

_____ / _____ / _____ X (s) per day Every _____ Hrs _____ / _____ / _____ X (s) per day Every _____ Hrs

_____ / _____ / _____ X (s) per day Every _____ Hrs _____ / _____ / _____ X (s) per day Every _____ Hrs

Various Allergies

- Aspirin
- Codeine
- Iodine
- Penicillin

- Latex
- Sulfa Drugs
- Erythromycin
- Barbiturates (Sleeping Pills)

Others: _____

Preferred Pharmacy _____ Phone: _____ - _____ - _____

I have read and answered the above questions to the best of my knowledge. I understand that it is my responsibility to notify Nu Smile and its doctors of any changes in my health history, medical test results, and / or medications. I acknowledge this and understand this may significantly affect the final outcome of my dental treatment result, potential side effects of "drug to drug" interactions and / or my health and / or medical condition(s).

Signature of Guest or Parent if minor

Date

Signature of Doctor