

GENERAL HEALTH INFORMATION

List all **health care providers** you are now working with: _____

Tell us about your current **health care** concerns: _____

Check all that apply to you regarding your past or current health status:

heart or blood problems heart murmur or mitral-valve prolapse taken antibiotics prior to dental appointments
 digestive problems allergies, chronic sinus artificial joint diabetes (or family history of) hepatitis
 cancer (or family history of) multiple sclerosis fainting, dizziness, seizures chronic/frequent headaches
 bone, joint, neck, back problems currently pregnant currently nursing reached menopause
others? _____

List all **surgeries** you have had with approximate dates: _____

List all **serious accidents, injuries** you have sustained and dates _____

List all **medications, supplements** you are currently taking _____

List all **allergies** _____

Do you use?	how much?		
<input type="checkbox"/> alcohol	_____	<input type="checkbox"/> dairy products	_____
<input type="checkbox"/> caffeine	_____	<input type="checkbox"/> wheat/gluten	_____
<input type="checkbox"/> tobacco	_____	<input type="checkbox"/> soy	_____
<input type="checkbox"/> sugar	_____	<input type="checkbox"/> drink water	_____

Do you exercise? _____ Consisting of _____

Do you practice any form of relaxation, meditation? (describe) _____

Describe your sleep quantity and quality _____

Other significant health issues? _____