

Joseph B. Silberman, DMD, FAGD

Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____

Are you taking any medications now? Yes No If yes, please list name and dosage:

Are you allergic or have adverse reaction to any medications? Yes No If yes, please list them:

Do you have a latex allergy? Yes No

Have you been hospitalized during the past five years? Yes No If yes, please describe:

Indicate which of the following you have had, or have at present:

- | | | | |
|----------------------------------|----------------------------------------------------------|----------------------|----------------------------------------------------------|
| Heart (Surgery, Disease, Attack) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swollen ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis A,B,or C | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV positive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sickle Cell disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruise easily | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Neurological disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting or dizzy spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychological Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you use more than two pillows to sleep? Yes No

Do you have or have you had any disease, condition or problem not listed? Yes No

If yes, please list: _____

Women: Are you pregnant? Yes, ___ months No Are you nursing? Yes No

Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____