

Patients Name _____

Date _____

Please circle all symptoms or conditions you currently have or had in the past:

AIDS	Excessive Thirst	Kidney Disease	Rash
Allergies	Emphysema	Leg Pain/ Numbness	Rheumatic Fever
Angina	Earache	Liver Disease	Ringing in Ears
Appendicitis	Ear Discharge	Loss of Hearing	SARS
Arm Pain	Feet Pain/Numbness	Loss of Sleep	Scarlet Fever
Arm Numbness	Fevers	Loss of Weight	Scars
Arthritis	Forgetfulness	Low Blood Pressure	Sciatica
Asthma	Frequent Urination	Lumbago	Shoulder Pain
Back Pain	Gas	Measles	Shoulder Numbness
Bleeding Disorders	Glaucoma	Migraine Headaches	Sinus Problems
Bleeding Gums	Hand Pain/Numbness	Multiple Sclerosis	Sores Not Healing
Blood in Urine	Hay Fever	Mumps	Stomach Aches/Pain
Blurred Vision	Headaches/Migraine	Nausea	Stroke
Bruise Easily	Heart Disease	Neck Pain/ Numbness	Sweats
Cancer	Hepatitis (any type)	Neuralgia	Swollen Ankles
Cataracts	Herpes	Neuritis	Thyroid Problems
Changes in Moles	High Blood Pressure	Nose Bleeds	Tuberculosis
Chemical Dependency	High Cholesterol	Pacemaker	Ulcers
Chest Pain	Hip Pain/Numbness	Painful Urination	Varicose Veins
Chills	HIV Positive	Persistent Cough	Venereal Disease
Diabetes Type I	Hives	Pneumonia	Vision Flashes
Diabetes Type II	Hoarseness	Polio	Vomiting
Depression	Indigestion	Poor Appetite	Vomiting Blood
Difficulty to Swallow	Irregular Heartbeat	Poor Circulation	
Dizziness/Fainting	Itching	Prostate Problem	
Double Vision	Jaundice	Rapid Heartbeat	

Woman Only: Are you pregnant? ☐ Yes ☐ No
 If you answered yes, what month are you presently in? _____

I certify that the above information on these two pages is correct to the best of my knowledge. I will not hold my dentist or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

David B. Kanner D.D.S.
Clifford I. Nebel D.D.S.
260-75 Union Turnpike
Glen Oaks, N.Y. 11004
718-343-1955

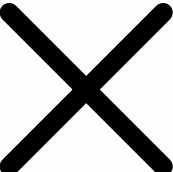
HEALTH HISTORY

Date _____

Last Name, First Name, Middle Initial _____


SS Number _____ - _____ - _____

Please enter all required information correctly. It is in your best interest to complete the following health questionnaire correctly so that we may provide you with the proper care as dictated by your medical condition.

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1. Have you ever been told by your physician or any other medical practitioner that you required pre-medication with antibiotics prior to Dental treatment? ____ Yes ____ No
 2. Have you had any joint replacement surgery(i.e. Hip, Knee, Shoulder, etc)? ____ Yes ____ No
 3. Do you have a Mitral Valve Prolapse(heart mummer)? ____ Yes ____ No
 4. Do you take any medications, which are used to thin your blood (i.e. cumadin, plavix, aspirin, or any similar type of medication)? ____ Yes ____ No
 5. Do you have slow wound healing? ____ Yes ____ No
 6. Have you had any adverse reactions to any dental or medical treatment of any kind? ____ Yes ____ No
 7. Are you allergic to any medications either prescription or over the counter? ____ Yes ____ No
 8. If you answered yes to questions 6 & 7 please list the medications, treatments and the reaction you had.

9. Please list all medications you are currently taking including the dosage.

10. Is there any information we should know about you in order to treat you properly?



Primary Care Physician's Name _____ Phone No. _____
Specialist Physician's Name _____ Phone No. _____



Emergency Contact Information
In case of a medical emergency please contact _____ @ _____ - _____ ext _____
Relationship to You _____