Patients Name _____ Date_____

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

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

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.

X 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.

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 _____