NOVA DENTAL

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Name: _____ Age: _____

Family Doctor's Name: _____

Most Recent Physical: _____ Purpose: _____

Your estimate of your overall general health? Poor O Fair O Good O

HAVE YOU EVER HAD THE FOLLOEWING? :

ALLERGIC REACTION TO:

- O Aspirin
- O Acetaminophen
- O Erythromycin
- O Codeine
- O Fluoride
- O Latex
- O Ibuprofen
- O Penicillin
- O Sulfa Drugs
- O Tetracycline
- O Local Anesthetic
- O Metals (ie. Gold, Stainless Steel)
- O Other: _____

- O Alcohol/Drug Dependency
- O Anemia or other blood disorders
- O Antidepresent medication
- O Arthritis
- O Artificial Prosthesis
- O Asthma
- O Chemotherapy
- O Cancer (Type:_____)
- O Diabetes
- O Emotional Problems
- O Emphysema
- O Epilepsy
- O Glaucoma
- O Head or neck injury
- O Heart Murmur
- O Heart Problems
- O Hepatitis (Type: _____)
- O High Blood Pressure
- O High Cholesterol
- O HIV/AIDS
- O Hives, Skin Rash, Hay Fever
- O Hormone Deficiency
- O Jaundice
- O Kidney Disease
- O Liver Disease
- O Lumps or swelling in the mouth
- O Prolong bleeding due to slight cut
- O Psychiatric Treatment
- O Radiation Therapy
- O Rheumatic Fever
- O Scarlet Fever
- O Sinus Problems
- O Stomach Ulcer
- O Stroke
- O Thyroid Disease
- O Tuberculosis
- O Tumor/Abnormal Growth
- O Viral Infections/Cold Sores
- O Hospitalization for Injury or Illness

ARE YOU CURRENTLY:

- O Presently being treated for any illness
- O Aware of a change in your health
- O Often exhausted or fatigued
- O Subject to frequent headaches
- O A heavy smoker
- O Often unhappy or depressed
- O Easily upset or irritated
- O FEMALE - Pregnant
- O MALE - Prostate Disorders

Please describe any current medical treatment, impending surgery, or other treatment that you are undergoing:

_____

_____

List any medications, herbal supplements, and/or vitamins taken within the last two years:

_____

_____

_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Signature: _____ **Date:** _____