

7. Do you have or have you ever had any of the following?

HEART/BLOOD VESSELS	YES	NO
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/discomfort.....	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of ankles.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE	YES	NO
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid condition/goiter.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>

TMJ	YES	NO
Clicking/popping of jaw.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening/closing jaw.....	<input type="checkbox"/>	<input type="checkbox"/>
Clenching/grinding teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Shifting of teeth.....	<input type="checkbox"/>	<input type="checkbox"/>
Change in bite.....	<input type="checkbox"/>	<input type="checkbox"/>
Muscle soreness (jaw).....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches when you wake up.....	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY	YES	NO
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea.....	<input type="checkbox"/>	<input type="checkbox"/>
Snoring.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing while lying down.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>

NERVOUS SYSTEM	YES	NO
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling.....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting.....	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>

BONE/MUSCLES	YES	NO
Arthritis/rheumatism.....	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints/limbs.....	<input type="checkbox"/>	<input type="checkbox"/>
Other.....	<input type="checkbox"/>	<input type="checkbox"/>

THROAT	YES	NO
Soreness/hoarseness.....	<input type="checkbox"/>	<input type="checkbox"/>

NOSE	YES	NO
Frequent nosebleeds.....	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems.....	<input type="checkbox"/>	<input type="checkbox"/>

DIGESTIVE SYSTEM	YES	NO
Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite.....	<input type="checkbox"/>	<input type="checkbox"/>

BLOOD	YES	NO
Bruise easily.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>

URINARY	YES	NO
Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Venereal disease.....	<input type="checkbox"/>	<input type="checkbox"/>

OTHER	YES	NO
Organ replacement.....	<input type="checkbox"/>	<input type="checkbox"/>
Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Tumors or growths.....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco use (any form).....	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use.....	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drug use.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, due date: _____		

8. Is there any disease, condition or problem not listed above that you think we should be aware of? If so, explain:

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform Dr. Semans at my next appointment. I hereby consent to all dental treatments as indicated by Dr. Semans in accordance with sound and prudent dental practice.

Signature of Patient,
Parent or Guardian _____

Date _____