DR EAN R. JAMES D.M.D., MD 860-583-6549 or 860-317-7400

HEALTH INFORMATION

PLEASE ANSWER ALL QUESTIONS. CIRCLE YES or NO AND PROVIDE ADDITIONAL INFORMATION REQUESTED

NAME:_____ AGE:_____ HEIGHT:_____ WEIGHT:_____

ARE YOU CURRENTLY UNDER THE CARE OF A MEDICAL DOCTOR?

IF YES, PLEASE EXPLAIN WHY:_____

_____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

ARE YOU TAKING ANY MEDICATIONS, PILLS, BLOOD THINNERS OR VITAMINS?

IF YES, PLEASE LIST AND WHY:_____

_____

HAVE YOU EVER BEEN HOSPITALIZED? IF YES, PLEASE EXPLAIN WHY:_____

HAVE YOU EVER BEEN PUT TO SLEEP? IF YES, PLEASE EXPLAIN WHY:_____

ARE YOU ALLERGIC OR HAVE HAD AND UNUSUAL REACTION TO PENICILLIN, ANESTHETICS, LATEX OR OTHER MEDICATIONS?

IF YES, PLEASE EXPLAIN WHY:_____

HAVE YOU EVER BEEN ON OR CURRENTLY TAKING SUBOXONE OR METHADONE? YES NO

ARE YOU PREGNANT OR SUSPECT THAT YOU MAY BE PREGNANT? YES NO

DO YOU SMOKE OR USE ANY OTHER FORM OF TOBACCO PRODUCTS? YES NO

HAVE YOU HAD RADIATION THERAPY FOR TUMORS, GROWTHS OR CANCER? YES NO

HAVE YOU EVER HAD ANY JOINT REPLACEMENTS? (KNEE, HIP, ETC..) YES NO

DO YOU HAVE A HISTORY OF ALCOHOLISM OR RECREATIONAL DRUG USE? YES NO

DO YOU HAVE A PACEMAKER, AN ARTIFICIAL HEART VALVE? YES NO

HAVE YOU EVER BEEN DIAGNOSED WITH MITRAL VALVE PROLAPSE? YES NO

TURN OVER

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ALLERGIES	YES	NO	HEART CONDITION	YES	NO
ANEMIA	YES	NO	HEART MURMUR	YES	NO
ASTHMA	YES	NO	HEPATITIS	YES	NO
BLOOD DISEASE	YES	NO	HERPES	YES	NO
BLEEDING DISORDERS	YES	NO	HIV/AIDS	YES	NO
BONE DISEASE	YES	NO	HIGH/LOW BLOOD PRESSUI	YES	NO
CANCER	YES	NO	JAUNDICE	YES	NO
CHEST PAIN	YES	NO	JAW PAIN/CLICKING	YES	NO
COPD	YES	NO	KIDNEY DISEASE	YES	NO
DIABETES	YES	NO	LIVER DISEASE	YES	NO
EAR ACHES	YES	NO	LUNG DISEASE	YES	NO
EMOTIONAL DISORDERS	YES	NO	NERVOUS CONDITIONS	YES	NO
EPILEPSY	YES	NO	PROLONGED BLEEDING	YES	NO
FAINTING	YES	NO	STOMACH PROBLEMS	YES	NO
GLAUCOMA	YES	NO	SICKLE CELL OR TRAITS	YES	NO
HEADACHE	YES	NO	TUBERCULOSIS	YES	NO
			ULCERS (MOUTH, ETC.)	YES	NO

DO YOU HAVE ANY DISEASES, CONDITIONS, OR PROBLEMS NOT LISTED ABOVE?

IF SO, PLEASE EXPLAIN:_____

_____

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH THAT WE HAVE NOT COVERED ON THIS FORM?

IF SO, PLEASE EXPLAIN:_____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

PATIENT/GUARDIANS SIGNATURE:_____ DATE:_____

DENTIST SIGNATURE:_____ DATE:_____