Check any of the following that you have had

____ Congenital Heart Defects
____ Heart Attack or Heart Problems
____ Stroke
____ Rheumatic Fever
____ Mitral Valve Prolapse
____ Anemia (Blood Disease)
____ Thyroid Problems
____ Chronic Bronchitis
____ STD (Syphilis, Gonorrhea, Herpes)
____ Angio Edema
____ Epilepsy or Seizures
____ Emphysema
____ Psychiatric Treatment
____ Radiation Therapy
____ Chemotherapy
____ Solid Organ Transplants
____ Stem Cell or Marrow Transplants
____ Arthritis
____ Artificial Heart Valve
____ Hepatitis (___A ___B___C)
____ Any Type of Transplant
____ Steroid Treatments
____ Sickle Cell Anemia
____ Angina
____ High Blood Pressure
____ Heart Pacemaker
____ Diabetes
____ AIDS or HIV Infections
____ Tuberculosis
____ Artificial Joints
____ Asthma
____ Kidney Dialysis
____ Indwelling Catheter
____ Systemic Lupus Erythematosus

Do you have any disease, condition, or problem not listed above? _____

Check any of the following that you have had or applies to you:

____ Sensitive Teeth
____ Bleeding Gums
____ Food Impaction
____ Pain around Ear
____ Tooth Ache
____ Swelling or Lump in Throat / Mouth
____ Unusual Sounds While Eating
____ Snoring
____ Blister on Lips or Mouth
____ Clenching or Grinding
____ Wear Dentures
____ Burning Tongue
____ Bad Breath
____ Decayed Teeth
____ Loose Teeth
____ Wear Partial Dentures

Print Name _____ Signature _____ Date _____