PLEASE ANSWER EACH QUESTION

1. Do you carry on normal activities ☐ Yes ☐ No Height ______ Weight ______
2. Would you say your health is ☐ Excellent ☐ Good ☐ Fair ☐ Poor
3. Are you now or have you in the past 5 years been treated by a physician ☐ Yes ☐ No
   If Yes, for what ______
4. Have you ever been hospitalized? ☐ Yes ☐ No For what? ______
5. Have you ever had a serious injury, illness or condition? ☐ Yes ☐ No Explain ______
6. List all medications that you take (include Coumadin, blood thinners, aspirin, birth control pills, vitamins, herbal medicines, over the counter) ______
7. List allergies to medications including Penicillin, Codeine, Aspirin, Novocaine (Other): ______
8. Have you ever had a reaction to or problem with local anesthesia (numb gums)? ☐ Yes ☐ No
9. Have you ever had a reaction to or problem with general anesthesia (go to sleep)? ☐ Yes ☐ No
10. Have you ever bled excessively after extractions of teeth or any other surgery? ☐ Yes ☐ No
11. Do you use cocaine, heroin, marijuana or other street or recreational drugs? ☐ Yes ☐ No
12. Do you use tobacco? ☐ Yes ☐ No How long? ______ How much? ______
13. Have you had anything to eat or drink in the past 8 hours? ☐ Yes ☐ No

CHECK BOX THAT APPLIES. HAVE YOU HAD ANY OF THE FOLLOWING?

☐ Yes ☐ No Heart Condition
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Stroke
☐ Yes ☐ No Heart Valve Replacement
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Joint Replacement
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Anemia
☐ Yes ☐ No Psychiatric Treatment
☐ Yes ☐ No HIV Positive or AIDS
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Asthma
☐ Yes ☐ No Liver Disorder
☐ Yes ☐ No Thyroid
☐ Yes ☐ No Headaches
☐ Yes ☐ No Pregnant now, mos. ______
☐ Yes ☐ No Bleeding Disorders
☐ Yes ☐ No TB
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Arthritis
☐ Yes ☐ No TMJ
☐ Yes ☐ No Cancer
☐ Yes ☐ No Convulsions or Seizures
☐ Yes ☐ No Dizziness, Fainting
☐ Yes ☐ No Cough, Cold, Sinus Trouble
☐ Yes ☐ No Snoring, Sleep Apnea
☐ Yes ☐ No Alcohol/Chemical Dependence
☐ Yes ☐ No Chemo/Radiation Therapy
☐ Yes ☐ No Circulatory Problems

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Drs. Strull & Strull, PSC or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form. I consent to the release of information for insurance purposes and authorize the responsible third party to pay directly Drs. Strull & Strull, PSC, insurance benefits due me for services rendered. I also understand that I am responsible for any unpaid balance due Drs. Strull & Strull, PSC, plus any and all costs incurred by Drs. Strull & Strull, PSC including reasonable attorney fees, in the collection of said unpaid balance.

Signed ______ Date ______

Witness ______