

Are you presently in good health? Yes No Have there been any changes in your health in the past year? Yes No
 Are you now under the care of a physician? Yes No For what reason? _____
 If 'Yes', Physician's name and phone number _____

Do you now, or have you ever had, any of the following diseases or medical problems ?

Please circle either the 'Y' or the 'N' for each of the following

Rheumatic Fever	Y N	Hemophilia	Y N	Kidney Problems	Y N
Rheumatic Heart Disease	Y N	Abnormal Bleeding	Y N	Are you on dialysis	Y N
Damaged Heart Valve	Y N	Excessive Bleeding	Y N	Diabetes	Y N
Mitral Valve Prolapse	Y N	Anemia	Y N	Low blood sugar	Y N
Heart Surgery	Y N	Do you bruise easily	Y N	Delayed or slow healing	Y N
Circulation Problems	Y N	Arthritis	Y N	Back and/or Neck problems	Y N
Heart valve replacement	Y N	Sickle cell disease	Y N	Problems with immune system	Y N
Vascular graft	Y N	Liver disease or Jaundice	Y N	Contagious diseases	Y N
Chest pain (Angina)	Y N	Blood transfusion	Y N	Infectious mononucleosis	Y N
Heart attack(s)	Y N	Hepatitis A (infectious)	Y N	Sexually transmitted disease	Y N
Heart murmur	Y N	Hepatitis B (serum)	Y N	History of drug abuse	Y N
High blood pressure	Y N	Hepatitis C	Y N	History of alcohol abuse	Y N
Low blood pressure	Y N	Cancer	Y N	Chronic fatigue or Night sweats	Y N
Irregular heart beat	Y N	Radiation treatment	Y N	Mental health problems	Y N
Cardiac pacemaker	Y N	Chemotherapy	Y N	Are you on a diet	Y N
Breathing problems	Y N	A tumor or growth	Y N	Pain or clicking of jaws when eating	Y N
Asthma	Y N	Stroke	Y N	Stomach ulcers or Colitis	Y N
Emphysema	Y N	Temporary loss of vision	Y N	Glaucoma or eye problems	Y N
Do you smoke	Y N	Epilepsy	Y N	Do you wear contact lenses	Y N
Bronchitis and/or chronic cough	Y N	Seizures and/or Convulsions	Y N	Overnight hospitalization	Y N
Lung disease	Y N	Fainting spells	Y N	Artificial joint or implant	Y N
Tuberculosis (T.B.)	Y N	Malignant Hyperthermia	Y N	Unhealed mouth sores	Y N
Hay fever and/or Sinus problems	Y N	Thyroid trouble	Y N	Other _____	Y N

Have you ever been put to sleep for surgery? Y N Was there ever an anesthetic problem with you or a blood relative? Y N

The use of recreational drugs with General Anesthesia or other I.V. medication can be dangerous to your health

Are you now taking, or have you taken, any types of these medications or drugs within the past 2 weeks ?

Amphetamines Y N Narcotics Y N Valium Y N Sleeping Pills Y N Marijuana Y N Steroids Y N
 Tranquilizers Y N Fosamax Y N Zometa Y N Blood thinners Y N Cocaine Y N Birth Control Y N
 Barbiturates Y N Aretia Y N Cocaine Y N Others _____

Have you ever taken prescription diet pills ? Y N Which ? ___Fen-phen (fenfluramine + phentermine) ___Redux (dexfenfluramine)
 ___Pondimin (fenfluramine) Have you had a medical exam to insure that your heart valves were not affected ? Yes No

Are you taking any other medications now? Y N If Yes, please list _____

Are you taking any nutritional supplements? Y N If Yes, please list _____

Are you allergic or sensitive to, or had a reaction to, any of the following ? Please circle Y or N for each item

Penicillin Y N Erythromycin Y N Pentothal Y N Valium Y N Local anesthetics Y N Sulfites Y N
 Codeine Y N Barbiturates Y N Aspirin Y N Latex Y N Others (please list) _____

Is there anything about your health that Dr. Schuman should be told, or anything you would like to explain to Dr. Schuman? Yes No

Is there anything about the appearance of your chin, upper and/or lower jaw, lips, and/or face, that displeases you? Yes No

Do you have any growths, moles, and/or skin tags on your face or neck that displease you that you and would like to be gone? Yes No

Have you had a cold, cough or upper respiratory infection in the past two weeks? Yes No

Do you become short of breath when you walk up a flight of stairs ? Yes No

Is snoring a problem for you and/or for others Yes No Would you like some information about snoring & sleep apnea Yes No

For Women: Are you pregnant? Yes No If YES, which month? _____ Is there a possibility of pregnancy ? Yes No
 Are you nursing? Yes No Antibiotics (such as Penicillin), may alter the effectiveness of Birth Control Pills

I certify that I have read and understand the questions above, and that the answers I have given are correct. I will not hold Dr. Schuman or any member of his staff responsible for any errors or omissions that I have made in completing this form and I agree to inform his office of any changes. This signature on my file is my authorization for the release of information necessary to process my claim. I authorize Dr. Schuman or staff to take x-rays and perform an Oral & Maxillofacial examination for the purpose of diagnosis and treatment planning for which there shall be a charge.

I hereby authorize payment to Dr. Schuman of any benefits otherwise payable to me.

 Patient, Parent, or Legal Guardian Date Staff member Date