L. Wayne Bossola, D.M.D.
Jennifer Zavoral, D.M.D.

Name_____ Phone (Home)_____ Height_____
Address_____ (Work)_____ Weight_____
_____ Date of Birth_____ Age_____
Physician_____ Physician Address_____
Physician Phone_____ Date of Last Complete Physical_____
Occupation_____ Referred By_____

1. What is your general state of health? _____
2. Are you now, or have you recently been under a physicians care? _____
3. Are you now, or within the past 6 months, have you taken any medications either prescription, over the counter, vitamins, or supplements? If yes, please list and include reasons: _____
_____
_____
4. Have you ever had a serious illness or operation? If yes, describe: _____
_____
5. Have you ever had joint replacement surgery? _____
6. Do you have any allergies? If yes, please list: _____
_____
7. Have you ever had a reaction to a local anesthetic, antibiotic, or other drug? If yes, describe: _____
_____
8. Have you ever had unexplained night sweats? _____
9. Are you pregnant? If yes, please not how long and the number of pregnancies: _____
10. Have you ever had hepatitis or been jaundiced? _____
11. Have you ever had a venereal disease? (Gonorrhea or Syphilis) _____
12. Have you ever had unusual blue or purple spots on your skin or mucous membrane? _____
13. Are you able to perform your daily activities without stress or strain? _____
14. Are your activities limited for any reason? _____
15. Have you ever had chest pains? _____
16. Have you ever had any shortness of breath? _____
17. Do you have a persistent cough or wheeze? _____
18. Do you ever have dizzy spells? _____
19. Do you ankles swell? When? _____
20. Have you ever had an organ transplant? _____
21. Have you ever been told you had a heart murmur, heart trouble, or lung trouble? If yes, please describe:
_____
22. Have you ever had prolonged bleeding following a cut, tooth extraction, or other injury? _____
23. Have you ever had a convulsion or a seizure? _____
24. Are you troubled by frequent headaches? _____
25. Are you a diabetic? If yes, please describe the length of treatment: _____
26. Have you ever had kidney or liver trouble? _____
27. Is there any history of tuberculosis, diabetes, or bleeding in your family? Please describe_____
_____
28. Do you smoke and/or drink? _____
29. Have you ever had a blood transfusion? _____

We want to stress that we must ask you these questions for your safety and the safety of others. Please alert the doctor if you:

- Know you are antibody positive for the AIDS virus or show of AIDS infection;
- Are male and have ever had sex with another man since 1977;
- Emigrated since 1977 from countries where the AIDS virus is common, such as Haiti or Central Africa;
- Have ever used non-prescription injectable drugs;
- Have engaged in prostitution since 1977, or had any sexual contact with a prostitute (male or female), within the last six months;
- Are a hemophiliac;
- Have a spouse or sexual partner who belongs to one of these groups.

YOU NEED NOT BE SPECIFIC AS TO WHICH ONE OF THE ABOVE MAY PERTAIN TO YOU.

SIGNATURE _____ DATE_____