MEDICAL HISTORY

Circle

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dentist office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   Physician's Name _____
   Address _____ Phone # _____
6. Have you taken any medicine or drugs during the past two years? _____ YES _____ NO
   Are you now taking any medicine, drugs or pills? ..... YES NO
   If yes, please list those drugs: _____
   _____
7. Are you allergic to any of the following medications?

Aspirin	Nitrous Oxide	Valium	Penicillin
Darvon	Erythromycin	Scopolamine	Other Antibiotics
Codeine	Tetracycline	Local Anesthetic	(Novacaine or Xylocaine)
Demerol	Percodan	Nembutal/Seconal	(Sleeping pills)

8. Are you aware of being allergic to any medication or substance? ..... YES NO
   If yes, please list: _____
9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	Artificial Joints (Hip, Knee)	Venereal Disease
Heart Disease or Attack	Cough	Hepatitis A (infectious)	(Syphilis, Gonorrhea)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)	Cold Sores
High Blood Pressure	Asthma	Liver Disease	Fever Blisters
Heart Murmur	Hay Fever	Yellow Jaundice	Epilepsy or Seizures
Rheumatic Fever	Sinus Trouble	Blood Transfusion	Fainting or Dizzy Spells
Congenital Heart Lesions	Allergies or Hives	Drug Addiction	Nervousness
Scarlet Fever	Diabetes	Hemophilia	Psychiatric Treatment
Artificial Heart Valve	Thyroid Disease	Bruise Easily	Sickle Cell Disease
Heart Pacemaker	X-Ray or Cobalt Treatment	Glaucoma	Stroke
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints	Kidney Trouble
AIDS/Immune	Arthritis	Cortisone Medicine	Ulcers
Deficiency Disease	Rheumatism	Herpes Simplex	Anemia
HIV Positive	Artificial Joint		

10. When you walk up stairs or take a walk, do you ever stop because of pain in your chest, or shortness of breath because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than 2 pillows to sleep? ..... YES NO
13. Have you lost or gained more than 10 pounds in the last year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
17. Do you have any disease, condition or problem not listed? ..... YES NO

FOR WOMEN ONLY:

Are you pregnant? ❑ YES ❑ NO If yes, what month? _____ Are you taking birth control pills? ❑ YES ❑ NO

CONSENT:

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that my be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient _____ Date _____ Witness _____

Parent of Responsible Party _____ Relationship to Patient _____