Health History

(Circle One)

1. Are you having pain or discomfort at this time?... YES NO
2. Do you feel very nervous about this dental treatment?.. YES NO
3. Have you ever had a bad experience in a dental office?..YES NO
4. Have you been a patient in the hospital during the last two years?...YES NO
5. Have you been under the care of a medical doctor during the past two years?
   Your Physician's Name:____ YES NO
   Address:____Phone:______________________________
   When was you last complete physical?____
6. Have you taken any medication or drugs in the past two years?...YES NO
   Are you currently taking any medication, drugs, or pills?..YES NO
   If yes, please list:____
7. Are you allergic or have you reacted adversely to any of the following medications?.......................YES NO
   If yes, please circle:

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	(Novocan or Xylocaine)
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	(Nembutal- Seconal)	Other Antibiotics

8. Are you aware of being allergic to any other medications or substances?...YES NO
9. Circle any of the following that apply to you now or in the past:

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

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath?..YES NO
11. Do your ankles swell during the day?...YES NO
12. Do you use 2 or more pillows to sleep?..YES NO
13. Have you lost or gained more than 10 lbs. in the past 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 that you have cancer or a tumor?..YES NO
17. Do you have any disease, condition, or problem not listed?...YES NO
    If yes, please explain:____

FOR WOMEN ONLY: Are you pregnant? ☐ YES ☐ NO If yes, what month?__________________________
Are you taking birth control? ☐YES ☐ NO

THE ABOVE INFORMATION IS TRUE.

The undersigned hereby authorizes Doctor to take x-rays, 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 may 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 that use of anesthetic agent embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine and due and payable at the time services are rendered, unless financial arrangements have been made.

PATIENT/RESPONSIBLE PARTY SIGNATURE_______________________________________DATE:_______________