# WELCOME

Patient's Name:____________________ Date of Birth______________

*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 been a patient hospitalized during the past two years? ............ YES NO
4. Have you been under the care of a medical doctor during the past two years? ............ YES NO
5. Have you taken any prescription or non-prescription medicine or drugs during the past two years?...... YES NO
   (If yes, please list on the OTHER SIDE.)
6. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine or any other drugs or medications? (list)______________________________YES NO
7. Have you ever had any excessive bleeding requiring special treatment? ............ YES NO
8. Circle any of the following which you have had or have at present:

| | | |
|---|---|---|
| Heart Failure | Emphysema | HIV Positive |
| 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 (Syphilis, Gonorrhea) |
| Heart Pacemaker | X-ray or Cobalt Treatment | Cold Sores |
| Heart Surgery | Chemotherapy (Cancer, Leukemia) | Genital Herpes |
| Artificial Joint | 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 |
| Mitral Valve Prolapse | Bruise Easily | |

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?............ YES NO
10. Do your ankles swell during the day?............ YES NO
11. Do you use more than 2 pillows to sleep?............ YES NO
12. Have you lost or gained more than 10 pounds in the past year?............ YES NO
13. Do you ever wake up from your sleep, short of breath?............ YES NO
14. Are you on a special diet?............ YES NO
15. Do you smoke, chew, use snuff or any other forms of tobacco?............ YES NO
16. Do you regularly consume more than one or two alcoholic beverages a day?............ YES NO
17. Have you ever taken any diet prescription drugs, such as, fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or any other weight loss products?............ YES NO
18. Has your medical doctor ever said you have cancer or a tumor?............ YES NO
19. Do you have any disease, condition or problem not listed?............ YES NO
20. WOMEN: Are you pregnant now?............ YES NO
    Are you practicing birth control?............ YES NO
    Do you anticipate becoming pregnant?............ YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or my medicines, I will inform the doctor of dentistry at the next appointment without fail.

PATIENT'S / GUARDIAN'S SIGNATURE____________________________________ DATE_______________

DENTIST'S SIGNATURE____________________________________ DATE_______________

# MEDICAL HISTORY