HEALTH HISTORY

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are associated with proper oral health care.

Please answer each question. Circle YES or NO where applicable.

MEDICAL HISTORY

1. Are you in good health? . . . . YES NO
2. Date of last physical examination_________/___________/____________
3. Are you now under the care of a physician? . . . . YES NO
   If so, what is the condition being treated?____
   ____
4. Have you ever been hospitalized? . . . . YES NO
   If so, please explain____
   ____
   ____
5. Are you taking any medicine? . . . . YES NO
   If so, What? ____
6. Have you been pre-medicated with antibiotics for your dental treatment? . . . . YES NO
7. Are you sensitive or allergic to anything? . . . . YES NO
   If so, What? ____
8. Do you have, or have you had any of the following: (Please check known conditions)

__Anemia
__Blood Transfusion
__Herpes
__Joint replacement
__Stroke
__Nervous Disorders
__Heart Murmur
__Tuberculosis (T.B.)
__Bruise Easily
__Hepatitis or Jaundice
__Angina Pectoris
__Venereal Disease
__Psychiatric Treatment
__Rheumatic Fever
__Hay Fever
__High Blood Pressure
__Chicken Pox
__Heart Ailments or Attack
__Cold Sores
__Pain in Jaw Joints
__Hemophilia
__Respiratory Disease
__Rheumatism
__Ulcers
__Kidney Disease
__Diabetes
__Allergies or Hives
__Glaucoma
__Cortisone Medicine
__Arthritis
__Emphysema
__Asthma
__Scarlet Fever
__Difficulty in Swallowing
__Cerebral Palsy
__Sinus Trouble
__X-Ray or Cobalt Treatment
__Blood Disease
__Fainting Spells or Seizures
__Drug Addiction
__Chemotherapy (Cancer, Leukemia)
__Tumors or Growths
__Radiation Treatment, any kind
__Epilepsy or Seizures
__Head Injuries
__Artificial Prosthesis
__Excessive Bleeding
__Liver Disease
__Congenital Heart Lesions
__Thyroid Disease
__Tonsillitis
__AIDS Related Complex

Other____
____

10. Do a Cardiac pacemaker, or have you had heart surgery? . . . . YES NO
11. Do you have any disease, condition or problem not listed? . . . . YES NO
12. (Women) Are you Pregnant? If so, how many months?_________________. . . . . YES NO
13. (Women) Do you take Birth Control Pills? . . . . YES NO

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? . . . . YES NO
2. Have you ever had any unfavorable reaction from a local anesthetic? . . . . YES NO
3. Have you had difficulty associated with any previous dental treatment? . . . . YES NO
   If so, explain____
4. How long since your last dental treatment? ____
5. How long since your last X-Rays? ____--------____
6. Does dental treatment make you nervous? . .. . YES NO
   If YES. Check __Slightly __Moderately __Extremely

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

DATE_____________SIGNATURE____

MEDICAL HISTIORY UPDATE

DATE____________________BY____
DATE____________________BY____
DATE____________________BY____
DATE____________________BY____