1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO
4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication or drugs? ..... YES NO

If yes, please list: _____

6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO
7. Have you ever taken Phen Fen? ..... YES NO
8. Indicate which of the following you have had or have at present. **Circle "yes" or "no" to each item.**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart Failure | YES | NO | Artificial Joints (hip, knee, etc.) | YES | NO | Hepatitis B (serum) | YES | NO |
| Heart Disease or Attack | YES | NO | Kidney Trouble | YES | NO | Venereal Disease | YES | NO |
| Angina Pectoris | YES | NO | Ulcers | YES | NO | A.I.D.S. | YES | NO |
| Congenital Heart Disease | YES | NO | Diabetes | YES | NO | H.I.V. Positive | YES | NO |
| Heart Murmur | YES | NO | Thyroid Problems | YES | NO | Cold Sores/Fever Blisters | YES | NO |
| High Blood Pressure | YES | NO | Glaucoma | YES | NO | Blood Transfusion | YES | NO |
| Arteriosclerosis | YES | NO | Cancer | YES | NO | Hemophilia | YES | NO |
| Mitral Valve Prolapse | YES | NO | Emphysema | YES | NO | Anemia | YES | NO |
| Artificial Heart Valve | YES | NO | Chronic Cough | YES | NO | Sickle Cell Disease | YES | NO |
| Heart Pacemaker | YES | NO | Tuberculosis | YES | NO | Bruise Easily | YES | NO |
| Heart Surgery | YES | NO | Asthma | YES | NO | Liver Disease | YES | NO |
| Rheumatic Fever | YES | NO | Hay fever | YES | NO | Yellow Jaundice | YES | NO |
| Arthritis | YES | NO | Allergies or Hives | YES | NO | Epilepsy or Seizures | YES | NO |
| Rheumatism | YES | NO | Sinus Trouble | YES | NO | Fainting or Dizzy Spells | YES | NO |
| Cortisone Medicine | YES | NO | Radiation Therapy | YES | NO | Nervousness | YES | NO |
| Drug Addiction | YES | NO | Chemotherapy | YES | NO | Tumors | YES | NO |
| Stroke | YES | NO | Hepatitis A (infectious) | YES | NO | Developmentally Disabled | YES | NO |
| | | | | | | Allergy to Latex | YES | NO |

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or because you are very tired? ..... YES NO
10. Do your ankles swell during the day? ..... YES NO
11. Do you use more than two 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 sleep and feel short of breath? ..... YES NO
14. Are you on a special diet? ..... YES NO
15. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO
    If yes, please list: _____
16. Have you ever taken any dietary supplements? ..... YES NO

FOR WOMEN ONLY:
Are you pregnant? ❑ Yes ❑ No What month? _____ Are you nursing? ❑ Yes ❑ No Are you taking birth control pills? ❑ Yes ❑ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature: _____ Date: _____

**Consent:**

1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication thereby indicated for such treatment in connection with (name of patient): _____ I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed to provide recommended treatment.

Patient: _____ Date: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____

# MEDICAL HISTORY