CONFIDENTIAL INFORMATION

Name_____ Birthdate_____ Physician(Family Doctor)_____

MEDICAL HISTORY

1. Are you having pain or discomfort at this time? YES NO

2. Do you feel nervous about having 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 in the past two years? YES NO

5. Have you been under the care of a medical doctor during the past two years? YES NO

6. Are you taking any medication or drugs YES NO

7. Do you have any allergies to medications? (ie: penicillin, codeine, local anaesthetic) YES NO

8. Have you ever had any excessive bleeding requiring special treatment? YES NO

9. Circle the following, which you have had or presently have?

Heart Failure	Emphysema	HIV/Aids
Heart Disease or attack	Cough	Hepatitis A,B or C
Angina Pectoris	Tuberculosis	Liver disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus trouble	Blood transfusion
Allergies/Hives	Drug Addiction	Scarlet Fever
Diabetes	Hemophilia	Artificial Heart Valve
Thyroid disease	Venereal disease	Pacemaker
X-ray treatment	Cold Sores	Heart surgery
Chemotherapy	Genital Herpes	Artificial Joint
Arthritis	Epilepsy/seizures	Anemia
Rheumatism	Fainting or Dizzy spells	Stroke
Cortisone medicine	Nervousness	Kidney trouble
Glaucoma	Psychiatric treatment	Ulcers
Pain in jaw joints	Cancer or tumor	Bruise easily

10. Do you have any disease, condition, or problem **NOT** listed? YES NO

11. Do you ever have chest pain or shortness of breath? YES NO

12. Do your ankles swell during the day? YES NO

13. Do you suffer from back problems? YES NO

14. Have you lost or gained any excessive weight in the past year? YES NO

15. Do you ever wake up from sleep, short of breath? YES NO

16. Are you on a special diet? YES NO

17. WOMEN ONLY: Are you pregnant? YES NO

TO THE BEST OF MY KNOWLEDGE,THE PRECEEDING ANSWERS ARE CORRECT AND IF THERE ARE ANY CHANGES IN MY HEALTH I WILL INFORM MY DENTIST

Date:_____ Signature (patient, parent or guardian)_____