Patient's Name

Last | First | Middle Initial | Date of Birth

1. Are you experiencing any pain or discomfort? ☐ Yes ☐ No
2. Are you in good health? ☐ Yes ☐ No
3. Has there been a change in your general health within the past Year? ☐ Yes ☐ No
4. Are you under the care of a physician? ☐ Yes ☐ No If Yes, what condition is being treated?

Physician

Address

Phone

5. Have you been hospitalized or had a serious operation or illness within the last five yrs? ☐ Yes ☐ No
6. Do you have or have you had any of the following diseases or problems? Please Select

○ Heart Failure	○ Pacemaker	○ Emphysema	○ Anemia	○ Diabetes
○ Heart Disease	○ Heart Surgery	○ Cough	○ Stoke	○ Thyroid Disease
○ Heart Attack	○ AIDS	○ Tuberculosis	○ Kidney Trouble	○ Xray or Cobalt Treat.
○ Blood Pressure	○ Hepatitis A	○ Asthma	○ Ulcers	○ Chemotheraphy
○ Heart Murmur	○ Hepatitis B	○ Hay Fever	○ Bruise Easily	○ Arthritis
○ Rheumatic Fev.	○ Liver Disease	○ Sinus Trouble	○ Sickle Cell	○ Rheumatism
○ Scarlet Fever	○ Jaundice	○ Allergies of Hives	○ Nervousness	○ Cortisone Medicine
○ Congential Heart Lesions	○ Artificial Heart Value	○ Artificial Joint	○ Pschiatric Treatment	○ Glaucome
		○ Pain jaw/joints		○ Fainting/Dizzy
○ Epilepsy/Seizures	○ Cold Sores	○ Blood Transfusion	○ Diet Drugs	○ STD/VD (Syphillis/Gonorrhea)

7. Are you taking any drug or medicine? ☐ Yes ☐ No
8. Are you allergic or have you reacted adversely to any drugs or medicines? ☐ Yes ☐ No If so, which ones?

○ Aspirin	○ Erythromycin	○ Novacaine of Xylocaine	○ Scopolamine	○ Other
○ Codenie	○ Local Anesthetic	○ Penicillin	○ Sleeping Pills	
○ Darvon	○ Nembutal/Seconal	○ Percodan	○ Tetracycline	
○ Demerol	○ Nitrous Oxide	○ Other Antibiotics	○ Vallum	

9. When you walk up stais or take a walk, do you ever have to stop because of pain in your chest? ☐ Yes ☐ No
10. Do your ankles swell during the day? ☐ Yes ☐ No
11. Have you had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No

If so, please explain

12. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ☐ Yes ☐ No
13. Do you have a disease, condition, or problem not listed above, if yes please explain? ☐ Yes ☐ No

Women Only: Are You pregnant ? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

If you are pregnant, what month? Are you nursing? ☐ Yes ☐ No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I made in the completion of the form.

Signature____ Date