MEDICAL HISTORY

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been hospitalized or under a care of a medical doctor during the past two years? ..... YES NO
3. Are you currently taking any medications? Please provide list or write on back of this form..... YES NO
4. Are you currently taking nitroglycerin pills? ..... YES NO
5. Are you currently taking blood thinners, including aspirin? ..... YES NO
6. **Are you allergic to or made sick by Penicillin, Advil, Codeine or Latex?** ..... YES NO
7. Are you allergic to any other drugs, medications or materials not listed? ..... YES NO
8. Have you ever had any excessive bleeding requiring special treatment? ..... YES NO
9. When walking, do you ever stop because of pain in chest or shortness of breath? ..... YES NO
10. Do you use more than 2 pillows to sleep? ..... YES NO
11. Do you ever wake up from sleep short of breath? ..... YES NO
12. Are you pregnant? ..... YES NO
13. Do you have any disease, condition or problem not listed? ..... YES NO
14. Do you desire any cosmetic changes to your teeth? ..... YES NO

15. PLEASE CIRCLE YES OR NO. DO YOU HAVE OR EVER HAD THE FOLLOWING:

Alcoholism	YES NO	Allergies/Hives	YES NO	Anemia	YES NO
Angina Pectoris	YES NO	Artificial Heart Valve	YES NO	***Artificial Joint**	YES NO
Arthritis	YES NO	Asthma	YES NO	Blood Transfusion	YES NO
Cancer	YES NO	Chemical Dependency	YES NO	Chemotherapy	YES NO
Cold Sores	YES NO	Congenital Heart Lesion	YES NO	Diabetes	YES NO
Emphysema	YES NO	Epilepsy or Seizures	YES NO	Faints/Dizzy	YES NO
Glaucoma	YES NO	Hay Fever	YES NO	Heart Attack	YES NO
Heart Disease	YES NO	Heart Failure	YES NO	Heart Murmur	YES NO
Heart Pacemaker	YES NO	Heart Surgery	YES NO	Hemophilia	YES NO
Hepatitis A	YES NO	Hepatitis B	YES NO	Hepatitis C	YES NO
High Blood Pressure	YES NO	HIV/AIDS	YES NO	Kidney Trouble	YES NO
Liver Disease	YES NO	Mitral Valve Prolapse	YES NO	Nervousness	YES NO
Pain in Jaw Joints	YES NO	Psychiatric Treatment	YES NO	Rheumatic Fever	YES NO
Scarlet Fever	YES NO	Sickle Cell Disease	YES NO	Sinus Trouble	YES NO
Stroke	YES NO	Thyroid Disease	YES NO	Tuberculosis (TB)	YES NO
Ulcers	YES NO	X-ray Treatment	YES NO	Yellow Jaundice	YES NO

***If you have an artificial joint:**

Joint that was replaced _____ Date of Placement _____

Treating Doctor & Number_____

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 if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

_____ _____

Date Signature of Patient, Parent or Guardian

CONSENT OF TREATMENT

I hereby authorize, consent to and request the performance of dental services. I further authorize, consent and request that the doctor do whatever procedures deem necessary.
I do also authorize and request the administration of such aesthetic, or anesthetics, as may be deemed advisable by the above named doctor.

_____ _____

Date Signature of Patient, Parent or Guardian