Health History

1. Are you having pain or discomfort at this time?.....Yes No
2. Do you feel very nervous about having dental treatment?.....Yes No
3. Have you ever had a bad experience in the dental office?.....Yes No
4. Have you been a patient in the hospital during the past two years?.....Yes No
5. Have you been under the care of a medical doctor during the past two years?.....Yes No
   Physician's Name_____
   Address_____ Phone #_____
6. Have you taken any medicine or drugs during the past two years?.....Yes No
   Are you now taking any medication, drugs or pills?.....Yes No
   If yes, list:_____
7. Are you allergic or have you reacted adversely to any of the following medications?.....Yes No

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	(Novocaine or Xylocaine)
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	Other Antibiotics	(Nembutal/Seconal)

8. Are you aware of being allergic to any other medications or substances?.....Yes No
   If yes, Please list:_____
9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	A.I.D.S.
Heart Disease or attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphillis,Gonorrhea)
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Fever Blisters
Artificial Joints (Hip, Knee)	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Cosmetic Surgery	Bruise Easily	

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?.....Yes No
11. Do your ankles swell during the day?.....Yes No
12. Do you use more than 2 pillows to sleep?.....Yes No
13. Have you lost or gained more than 10 pounds in the past year?.....Yes No
14. Do you ever wake up from sleep short of breath?.....Yes No
15. Are you on a special diet?.....Yes No
16. Has your medical Doctor ever said you have cancer or a tumor?.....Yes No
17. Do you have any disease, condition, or problem not listed?.....Yes No

FOR WOMEN ONLY:

Are you pregnant? Yes No If yes, what month?_____. Are you taking birth control pills? Yes No

ABOVE INFORMATION IS TRUE

PATIENT SIGNATURE_____DATE_____/_____/_____