HEALTH HISTORY

CIRCLE

1. Are you feeling pain or discomfort at this time?..... YES NO
2. Have you had a medical examination in the last year?..... YES NO
3. Do you feel very anxious about having dental treatment?..... YES NO
4. Have you been a patient in the hospital during the past two years?..... YES NO
5. Please state your physician's Name_____ Phone #_____
6. If you are using any medication now, please list _____
7. Are you allergic or have you reacted adversely to any of the following medications? -please circle-

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	Novocain
Codeine	Tetracyline	Penicillin	Sleeping Pills
Demerol	Percodan	Other Antibiotics	Nembutal/Seconal

8. Are you aware of being allergic to any other medications or substance?..... YES NO
9. Circle any of the following which you have had or have at present:

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

10. **Do you wish to speak privately to the Doctor about any medical condition? YES NO**
11. When walking up stairs or taking a walk, do you ever stop because of pain your chest?..... YES NO
12. Do your ankles swell during the day?..... 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 every said you have a cancer or tumor?..... YES NO
17. Do you have a tendency to faint?..... YES NO
18. Do you have frequent severe headaches?..... YES NO
20. Have you had a regular dental examination (annually) in the past?..... YES NO
21. Do you have any disease, condition, or problem not listed?..... YES NO

FOR WOMEN ONLY Are you pregnant? YES NO If yes, what month?_____

CONSENT

The undersigned hereby authorizes Doctor, upon consultation and direct consent from patient to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ further to my consultation and direct consent. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements including insurance or otherwise, have been made.

Patient Signature_____ Date_____/_____/_____

(604)576-6830

Medical Alert