

Medical History

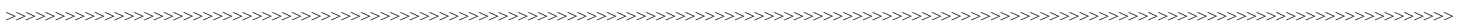
1. Are you having pain or discomfort at this time? YES... NO
2. Do you feel very nervous about having dental treatment..... YES... NO
3. Have you ever had a bad experience in a dental office or during treatment?..... YES... NO
4. Have you ever been hospitalized?..... YES... NO
5. Have you seen a medical doctor in the past two years..... YES... NO
6. Have you taken any medicine or drugs in the past two years?..... YES... NO
7. Are you allergic to (i.e. itching, rash, hives, swelling of hands, feet, eyes), had a reaction to or made sick by penicillin, aspirin, codeine or any medication?..... YES... NO
8. Have you ever had any excessive bleeding requiring special treatment?..... YES... NO
9. Have you ever been treated with bisphosphonates (i.e. Fosamax, Boniva, Actonel, Zometa)?..... YES... NO
10. CIRCLE any of the following which you have had or have at present, or subject to

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|--------------------------------|----------------------------|----------------------------|
| Heart Murmur/MVP | Emphysema | AIDS or HIV |
| Heart Disease or Attack | Cough | Hepatitis ___A___B___C |
| Angina Pectoris (Chest Pain) | Tuberculosis (TB) | Hepatitis (other) |
| High Blood Pressure | Asthma | Liver Disease |
| Low Blood Pressure | COPD | Blood Transfusion |
| Congenital Heart Disease | Hay Fever | Alcohol Abuse |
| Scarlet Fever | Sinus Trouble | Drug Addiction |
| Artificial Heart Valve | Allergies/Hives | Hemophilia |
| Heart Pacemaker/Defibrillator | Diabetes | Venereal Disease (VD) |
| Heart Surgery | Thyroid Disease | Cold Sores |
| Artificial Joint | Radiation Therapy | Herpes Virus |
| Anemia | Chemotherapy | Epilepsy/Seizures |
| Stroke or TIA | Arthritis | Fainting/Dizzy Spells |
| Kidney Trouble | Cortisone/Steroid Therapy | Anxiety/Emotional Disorder |
| Ulcers | Glaucoma | Psychiatric Treatment |
| Gastrointestinal Disease | Pain in Jaw Joints (TMJ) | Depression |
| Lung Disease | Neurological Disease | Sickle Cell Disease |
| Reaction to Local Anesthesia | Autoimmune Disease | Bruise easily |
| Reaction to General Anesthesia | Osteoporosis or Osteopenia | Other _____ |

11. 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 tired?..... YES... NO
12. Do your ankles swell during the day? YES... NO
13. Do you use more than 2 pillows to sleep? YES... NO
14. Have you lost or gained more than 10 pounds 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? If so, for what? YES... NO
17. Has a doctor ever said you have a cancer or tumor? YES... NO
18. Do you have any disease, condition, or problem not listed? YES... NO
19. WOMEN: Are you pregnant now? YES... NO
 Are you practicing birth control? YES... NO
 Do you anticipate becoming pregnant? YES... NO
20. Do you wear contact lenses? YES... NO
21. Are you taking any medication? List..... YES... NO

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 at the next appointment without fail.

 Date Signature or Patient, Parent or Guardian Witness



 Date Additions-if none so indicate Signature Witness