All information is completely confidential.

NAME_____DATE_____

1. PHYSICIAN'S NAME_____CITY_____PHONE_____
2. ARE YOU TAKING ANY MEDICINES OR DRUGS? YES NO (PLEASE LIST IF YES) _____

_____

3. ARE YOU ALLERGIC TO ANY MEDICINES OR DRUGS? YES NO (PLEASE LIST IF YES) _____

_____

4. HAVE YOU BEEN A PATIENT IN THE HOSPITAL DURING THE LAST TWO YEARS? YES NO
5. DO YOU HAVE A HISTORY OF CHEMICAL DEPENDENCY? YES NO
6. HAVE YOU HAD OR DO YOU HAVE AT PRESENT THE FOLLOWING? **CIRCLE "YES" OR "NO' FOR EACH ITEM**

HISTORY OF ENDOCARDITIS	YES	NO	CHRONIC COUGH	YES	NO
CONGENITAL HEART DISEASE (CHD)	YES	NO	TUBERCULOSIS	YES	NO
ORGAN TRANSPLANT	YES	NO	ASTHMA	YES	NO
RENAL DIALYSIS	YES	NO	LATEX ALLERGY	YES	NO
HEART TROUBLE	YES	NO	DRUG ALLERGY	YES	NO
ARTIFICIAL HEART VALVE	YES	NO	CANCER	YES	NO
HEART PACEMAKER	YES	NO	RADIATION THERAPY	YES	NO
HIGH BLOOD PRESSURE	YES	NO	CHEMOTHERAPY	YES	NO
STROKE	YES	NO	HEPATITIS	YES	NO
ARTHRITIS	YES	NO	VENEREAL DISEASE OR STD	YES	NO
SPECIAL DIET	YES	NO	HIV OR AIDS	YES	NO
ARTIFICIAL JOINT REPLACEMENT	YES	NO	HEMOPHILIA	YES	NO
KIDNEY DISEASE	YES	NO	SICKLE CELL DISEASE	YES	NO
ULCERS	YES	NO	LIVER DISEASE	YES	NO
DIABETES	YES	NO	NEUROLOGICAL DISORDER	YES	NO
THYROID PROBLEMS	YES	NO	EPILEPSY OR SEIZURES	YES	NO
GLAUCOMA	YES	NO	FAINTING OR DIZZY SPELLS	YES	NO
EMPHYSEMA	YES	NO	PSYCHIATRIC CARE	YES	NO

7. LIST ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE _____

_____

8. WOMEN: ARE YOU **PREGNANT**? YES NO **NURSING**? YES NO **TAKING BIRTH CONTROL PILLS**? YES NO
9. PERSON TO NOTIFY IN CASE OF AN EMERGENCY_____PHONE_____

"I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication."

SIGNATURE_____DATE_____

FOR DR. ONLY: PREMED Y N ALLERGIES Y N MEDICATIONS Y N

DR. INITIAL_____

MEDICAL HISTORY