

HEALTH HISTORY

CIRCLE

1. Are you having jaw pain or discomfort at this time? Yes No
2. Do you feel very nervous about having ortho treatment?..... Yes No
3. Have you been a patient in the hospital during the past two years? Yes No
4. Have you been under the care of a medical doctor during the past two years? Yes No
Physician's Name _____
Address _____ Phone _____
5. Have you taken any medicine or drugs during the past two years?..... Yes No
If yes, please list: _____
6. Are you now taking any medication, drugs or pills? Yes No
If yes, please list: _____
7. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?..... Yes No
8. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.

Heart Trouble.....	Yes	No	Tuberculosis	Yes	No	Hepatitis B	Yes	No
Angina Pectoris	Yes	No	Asthma	Yes	No	Liver Disease.....	Yes	No
High/Low Blood Pressure	Yes	No	Hay Fever	Yes	No	Yellow Jaundice.....	Yes	No
Heart Murmur	Yes	No	Sinus Trouble.....	Yes	No	Blood Transfusion.....	Yes	No
Rheumatic Fever	Yes	No	Allergies or Hives.....	Yes	No	Drug Addiction	Yes	No
Congenital Heart Lesions	Yes	No	Diabetes	Yes	No	Hemophilia.....	Yes	No
Scarlet Fever	Yes	No	Thyroid Disease.....	Yes	No	Venereal Disease		
Artificial Heart Valve	Yes	No	Chemotherapy			(Syphilis, Gonorrhoea).....	Yes	No
Heart Pacemaker.....	Yes	No	(Cancer, Leukemia)	Yes	No	Cold Sores.....	Yes	No
Heart Surgery	Yes	No	Arthritis	Yes	No	Epilepsy or Seizures.....	Yes	No
Artificial Joints (Hip, Knee)	Yes	No	Rheumatism	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Anemia	Yes	No	Cortisone Medicine.....	Yes	No	Psychiatric Treatment.....	Yes	No
Stroke	Yes	No	Glaucoma	Yes	No	Sickle Cell Disease.....	Yes	No
Kidney Trouble.....	Yes	No	Pain in Jaw Joints.....	Yes	No	Bruise Easily.....	Yes	No
Ulcers	Yes	No	A.I.D.S. / HIV+	Yes	No			
Cosmetic Surgery	Yes	No	Adenoids Removed	Yes	No			
Endocrine Disorders.....	Yes	No	Tonsils Removed	Yes	No			
Emphysema.....	Yes	No	Hepatitis A (infectious).....	Yes	No			
9. 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
10. Are you pregnant or think you may be pregnant? Yes No
11. Do you do any of the following (please circle): heavy snoring, mouth breathing, thumb sucking, tongue thrusting? .. Yes No
12. Are you on a special diet? Yes No
13. Do you have any disease, condition or problem not listed? Yes No
14. **Do you require premedication prior to dental cleanings?** **Yes No**
If yes please explain: _____

CONSENT:

The undersigned hereby authorizes Doctor 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*) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I understand that where appropriate, bureau reports may be obtained. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient: _____ Date _____ Doctor Signature _____ Date _____