

HEALTH HISTORY

CIRCLE

1. Does patient have jaw pain or discomfort at this time? Yes No
2. Does patient feel very nervous about having ortho treatment?..... Yes No
3. Has patient been in the hospital during the past two years?..... Yes No
4. Has patient been under the care of a medical doctor during the past two years? Yes No

Physician's Name _____

Address _____ Phone _____

5. Has patient taken any medicine or drugs during the past two years?..... Yes No
If yes, please list: _____

6. Is patient now taking any medication, drugs or pills? Yes No
If yes, please list: _____

7. Are you aware of patient being allergic to or having you ever reacted adversely to any medication or substance? ... Yes No

8. Please circle any of the following the patient had or has at present.

Heart Trouble	Tuberculosis	Hepatitis A (infectious)
Angina Pectoris	Asthma	Hepatitis B
High Blood Pressure	Hay Fever	Liver Disease
Heart Murmur	Sinus Trouble	Yellow Jaundice
Rheumatic Fever	Allergies or Hives	Blood Transfusion
Congenital Heart Lesions	Diabetes	Drug Addiction
Scarlet Fever	Thyroid Disease	Hemophilia
Artificial Heart Valve	X-ray or Cobalt Treatment	Venereal Disease
Heart Pacemaker	Chemotherapy	(Syphilis, Gonorrhea)
Heart Surgery	(Cancer, Leukemia)	Cold Sores
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	A.I.D.S.	Bruise Easily
Endocrine Disorders	Adenoids Removed	
Emphysema	Tonsils Removed	

9. When the patient walks up stairs or takes a walk, does he ever have to stop because of pain in his chest, or shortness of breath, or because he is very tired? Yes No

10. Is the patient pregnant or do you think she may be pregnant? Yes No

11. Has the patient lost or gained more than 10 pounds in the past year? Yes No

12. Does the patient ever wake up from sleep short of breath?..... Yes No

13. Is the patient on a special diet?..... Yes No

14. Has a medical doctor ever said the patient has cancer or a tumor? Yes No

15. Does patient have any disease, condition or problem not listed? Yes No

16. Does the patient 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, credit bureau reports may be obtained.

Patient: _____ Date _____ Doctor Signature _____ Date _____

if over 18 years old

Parent or Responsible Party _____ Relationship to Patient _____