MEDICAL INFORMATION

1. Are you having pain or discomfort at this time? **Yes No**

2. Have you been a patient in the hospital during the past 2 years? **Yes No**

3. List any medications or drugs you are presently taking and for what purpose (include any premedications):

_____

_____

_____

4. List any medications or anesthetics you are sensitive or allergic to:

_____

_____

5. Indicate which of the following items you have or have had in the past by circling **Yes** or **No** next to each item.

Heart Failure	Yes	No	Artificial Joints (list below)	Yes	No	Allergic/Sensitive to Latex	Yes	No
Heart Disease or Attack	Yes	No	Kidney Trouble	Yes	No	Allergies or Hives	Yes	No
Angina (chest pain)	Yes	No	Ulcers	Yes	No	Hepatitis	Yes	No
Congenital Heart Disease	Yes	No	Sinus Trouble	Yes	No	Liver Disease	Yes	No
Heart Murmur	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
High Blood Pressure	Yes	No	Chronic cough	Yes	No	Yellow Jaundice	Yes	No
Arteriosclerosis	Yes	No	Tuberculosis	Yes	No	Hemophilia	Yes	No
Mitral Valve Prolapse	Yes	No	Asthma	Yes	No	Anemia	Yes	No
Artificial Heart Valve	Yes	No	Hay Fever	Yes	No	Sickle Cell Disease	Yes	No
Heart Pacemaker	Yes	No	Cancer	Yes	No	Venereal Disease	Yes	No
Heart Surgery(list below)	Yes	No	Chemotherapy or Radiation	Yes	No	HIV Positive /A.I.D.S.	Yes	No
Rheumatic Fever	Yes	No	Migraines	Yes	No	Mental Illness	Yes	No
Fainting or Dizzy Spells	Yes	No	Tumors	Yes	No	Bruise Easily	Yes	No
Stroke	Yes	No	Arthritis	Yes	No	Cold Sores/Fever Blisters	Yes	No
Epilepsy or Seizures	Yes	No	Rheumatism	Yes	No	Nervousness /Anxiety	Yes	No
Diabetes (TYPE:____)	Yes	No	Cortisone Medicine	Yes	No	Glaucoma	Yes	No
Thyroid Problems	Yes	No	Drug Addiction / Alcoholism	Yes	No	Developmentally Disabled	Yes	No

6. Do you have or have you had any disease, condition, or problem not listed? **Yes No**
   If yes, please list:

_____

_____

7. For Women Only:

Are you pregnant? **Yes** (____months) **No** Are you nursing ? **Yes No** Are you taking birth control pills? **Yes No**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient / Parent Signature:_____ Date: _____