Heart (Surgery, Disease, Attack)	○Yes	○No	Emphysema……	○Yes	○No	Cold Sores……	○Yes	○No
Chest Pain …….	○Yes	○No	Chronic Cough……	○Yes	○No	Fever Blisters……	○Yes	○No
Congenital Heart Disease..	○Yes	○No	Cancer……	○Yes	○No	Blood Transfusion……	○Yes	○No
Heart Murmur……	○Yes	○No	Tuberculosis ……	○Yes	○No	Hemophilia……	○Yes	○No
High Blood Pressure……	○Yes	○No	Asthma ……	○Yes	○No	Sickle Cell Disease……..	○Yes	○No
Mitral Valve Prolapse……..	○Yes	○No	**Sleep Apnea**……. .	○Yes	○No	Liver Disease……	○Yes	○No
Artificial Heart Valve……	○Yes	○No	**Latex Sensitivity** ……..	○Yes	○No	Neurological Disorders…	○Yes	○No
Heart Stent/ Shunt…….	○Yes	○No	Allergies or Hives …….	○Yes	○No	Epilepsy or Seizures……	○Yes	○No
Heart Pacemaker……	○Yes	○No	Radiation Therapy…….	○Yes	○No	Fainting or Dizzy Spells..	○Yes	○No
Rheumatic Fever…….	○Yes	○No	Chemotherapy ……	○Yes	○No	Nervous/ Anxious……..	○Yes	○No
Arthritis/ Rheumatism……..	○Yes	○No	Tumors……	○Yes	○No	Psychiatric Care……	○Yes	○No
Stroke…… ……	○Yes	○No	Hepatitis A (Infectious).	○Yes	○No	Sinus Trouble…….. .	○Yes	○No
Artificial Joints……..	○Yes	○No	Hepatitis B (Serum)…..	○Yes	○No	**Allergy to Jewelry**…….	○Yes	○No
Kidney Trouble…….	○Yes	○No	Venereal Disease……..	○Yes	○No	**Allergy to Metal**……..	○Yes	○No
Diabetes…… ……	○Yes	○No	A.I.D.S…… …….	○Yes	○No	**TMJ Disorder**…… …..	○Yes	○No
Thyroid Problems……	○Yes	○No	H.I.V. Positive…… …	○Yes	○No	Smoke / Chew Tobacco..	○Yes	⊙No

MEDICAL HISTORY

Indicate which of the following you have had, or have at present. Circle "yes or "no" to each item.

Have you been prescribed a C-Pap device? ○Yes ○No
If yes, do you currently use it?

Do you have or have you had any disease, condition or problem not listed? ○Yes ○No
If yes, please list _____

Are you under the care of a physician? ○ Yes ○No
If yes, please explain _____
Name of physician _____

Are you taking any medication, drugs or pills now? ○Yes ○No
If yes, please list: _____
_____

Are you aware of having an allergy (or adverse reaction) to any medication or substance? ○Yes ○No
If yes, please list: _____

Women

Are you: **Pregnant?** Yes○_____Months No⊙ **Nursing?**○Yes ○No **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 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. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of **(Name of Patient)** _____**'s** dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks; I understand that I can ask for a complete recital of any possible complications.

Signature _____ **Date** _____ **Witness** _____

Parent or Responsible Party _____ **Relationship to Patient** _____