PERSONAL INFORMATION

_____

HOW WOULD YOU LIKE TO BE ADDRESSED? (NICKNAME)

_____

DO YOU HAVE ANY SPECIAL INTERESTS OR HOBBIES?

MEDICAL HISTORY

HEIGHT: _____, WEIGHT: _____lbs., BLOOD PRESSURE: _____, SpO2: _____, HR: _____/min., RESPIR: _____/min

1.	**Are you having pain or discomfort at this time?.....**	**_____YES**	**_____NO**
2.	**Are you usually very nervous about having dental treatment?.....**	**_____YES**	**_____NO**
3.	**Do you feel very nervous about having root canal treatment?.....**	**_____YES**	**_____NO**
4.	**Have you ever had a bad experience in a dental office?.....**	**_____YES**	**_____NO**
5.	**Have you been a patient in hospital in the past two years?.....**	**_____YES**	**_____NO**
6.	**Have you been under the care of a medical doctor in the past two years?.....**	**_____YES**	**_____NO**
7.	**Have you taken any medications or drugs during the past two years?.....**	**_____YES**	**_____NO**
8.	**Are you allergic or made sick by penicillin, aspirin, codeine, or any other drug or medication?.....**	**_____YES**	**_____NO**
9.	**Have you had any excessive bleeding requiring special treatment?.....**	**_____YES**	**_____NO**
10.	**Circle any of the following conditions in which you have had or have at the present time:**		

Heart Failure	**Emphysema**	**AIDS**
Heart Disease or Attack	**Cough**	**Hepatitis A (infectious)**
Angina Pectoris	**Tuberculosis (TB)**	**Hepatitis B (serum)**
High Blood Pressure	**Asthma**	**Liver Disease**
Heart Murmur	**Hay Fever**	**Yellow Jaundice**
Rheumatic Fever	**Sinus Trouble**	**Blood Transfusion**
Congenital heart Lesions	**Allergies or Hives**	**Drug or Alcohol Addiction**
Scarlet Fever	**Diabetes**	**Hemophilia**
Artificial heart Valve	**Thyroid Disease**	**Venereal Disease (Syphilis…)**
Heart Pacemaker	**X-ray or Cobalt Treatment**	**Cold Sores**
Heart Surgery	**Chemotherapy (Cancer, Leukemia)**	**Genital Herpes**
Artificial Joint	**Arthritis**	**Epilepsy or Seizures**
Anemia	**Rheumatism**	**Nervousness**
Stroke	**Cortisone Medicine**	**Psychiatric Treatment**
Kidney Trouble	**Glaucoma**	**Sickle Cell Disease**
Ulcers	**Pain in Jaw Joint**	**Bruise Easily**

11.	**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**
12.	**Do your ankle swell during the day?.....**	**_____YES**	**_____NO**
13.	**Must you prop up your head in order to sleep comfortably?.....**	**_____YES**	**_____NO**
14.	**Have you lost or gained more than 10 pounds in the last year?.....**	**_____YES**	**_____NO**
15.	**Do you ever wake up from sleep short of breath?.....**	**_____YES**	**_____NO**
16.	**Are you on a special diet?.....**	**_____YES**	**_____NO**
17.	**Has you medical doctor ever said you have a cancer or tumor?.....**	**_____YES**	**_____NO**
18.	**Do you have any disease, condition, or problem not listed?.....**	**_____YES**	**_____NO**
WOMEN:	**Are You pregnant now?.....**	**_____YES**	**_____NO**
	Are you taking oral contraceptives?.....	**_____YES**	**_____NO**
	Do you think you might be pregnant at this time?.....	**_____YES**	**_____NO**

To the best of my knowledge, all of the above information is true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

_____

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN **TODAY'S DATE**