PERSONAL INFORMATION

_____

HOW WOULD YOU LIKE TO BE ADDRESSED? (NICKNAME) AGE

_____

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