PERSONAL INFORMATION

HOW WOULD YOU LIKE TO BE ADDRESSED? (NICKNAME)

AGE

DO YOU HAVE ANY SPECIAL INTERESTS OR HOBBIES?

MEDICAL HISTORY

1. Are you having pain or discomfort at this time?	HEIGHT:, WEIGHT:lb	s., BLOOD PRESSURE:, SpO2:	, HR:/min., RESPIR:/min.	
2. Are you usually very nervous about having cost canal treatment?				
3. Do you feel very nervous about having root canal treatment?	2. Are you usually very nervous about having dental treatment?			
5. Have you been a patient in hospital in the past two years?	Jo Do you feel very nervous about having root canal treatment? YES			
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 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: YES NO Heart Disease or Attack Cough Hepatitis A (infectious) Angina Pectoris Tuberculosis (TB) Hepatitis B (serum) High Blood Pressure Akthma Liver Disease Heart Disease or Attack Cough Henotification Cough there is the pressure Akthma Liver Disease Heart Murmur Hay Fever Yellow Jaundice Rheumatic Fever Diabets Drug or Alcohol Addiction Scartet Fever Diabets Hemothismin Artificial heart Valve Thyroid Disease Venereal Disease (Syphilis) Artificial Joint Arthrifis Epilepse <td< td=""><td></td><td></td><td></td></td<>				
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chest, or shortness of breath, or because you are very tired				
NO YES NO				
12. Do your ankles swell during the day?		th, or because you are very tired		
NO YES NO YES 14. Have you lost or gained more than 10 pounds in the last year?		ng the day?	YES	
NO YES NO NO NO				
14. Have you lost or gained more than 10 pounds in the last year?				
15. Do you ever wake up from sleep short of breath?	14. Have you lost or gained more than 10 pounds in the last year? YES			
16. Are you on a special diet?	15. Do you ever wake up from sleep short of breath?			
17. Has your medical doctor ever said you have a cancer or tumor?	16. Are you on a special diet?YES			
18. Do you have any disease, condition, or problem not listed?	17. Has your medical doctor ever said you have a cancer or tumor?			
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	18. Do you have any disease, condition, or problem not listed?			
Are you taking oral contraceptives?YES	WOMEN: Are You pregnant now?			
Do you think you might be pregnant at this time?YES	Are you taking	oral contraceptives?	YES	
		ou might be pregnant at this time?	YES	

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.