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	**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 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**