GENERAL HEALTH INFORMATION AND MEDICAL HISTORY

(Please circle your answers)

1. Are you under a Doctors care at this time? Yes No

If yes explain: ____________________

Doctor's Name: ____________________ Telephone: ( ) ____________________

2. Have you ever been treated for?

a	Rheumatic Fever	Yes	No
b.	Heart condition	Yes	No
c.	High Blood Pressure	Yes	No
d	Any blood disease	Yes	No
e.	Lung Disease	Yes	No
f.	Tuberculosis	Yes	No
g.	Diabetes	Yes	No
h.	Liver problems	Yes	No
i.	Yellow Jaundice	Yes	No
j	Infectious Hepatitis	Yes	No
k	Thyroid or Kidney problems	Yes	No
l	Veneral disease	Yes	No
m.	Fainting or dizzy spells	Yes	No
o	Allergies	Yes	No
p	AIDS	Yes	No

3. Have you ever had prolonged bleeding for injury or previous extractions? Yes No
4. Have you ever had a reaction from a local anesthesia such as novacaine? Yes No
5. Are you allergic to any drugs or medicines? ____________________ Yes No
6. Are you taking any drugs or medicines now? ____________________ Yes No
7. Are you pregnant? Yes No
8. Are you allergic to latex? Yes No
9. Have you ever taken Phen-Fen? Yes No
10. Do you have condition of Glaucoma? Yes No
11. Do you take aspirin daily? Yes No
12. Do you have a pacemaker, valvular replacement and/or prosthetic joints Yes No

DENTAL INFORMATION

1. When did you last visit a dentist? ____________________
2. What was done? ____________________
3. Why are you here today? ____________________
4. Have you had any serious trouble associated with any previous dental treatment? Yes No

   Explain: ____________________
5. Do you have any disease or problem not listed above we should know about? Yes No

   Explain: ____________________

I have filled out this Health Questionnaire completely. I have advised you of all medical problems of which I am aware. I hereby Consent to the administration of anesthesia and the dental treatment specified by Dr.______
I have been informed of all risks involved in my dental treatment and anesthesia, including possible blood loss and infection.

____________________ ____________________ ____________________

Patient's Signature Date Doctor's Signature