HEALTH HISTORY

Name: _____ **(Circle One)**

1. **Are you having pain or experiencing discomfort at this time? ……. YES NO**
2. **Do you feel nervous about having dental treatment or have you had a bad experience in a dental office? ……... YES NO**
3. **Have you been a patient in the hospital during the past two years? ……..…… YES NO**
4. **Have been under the care of a medical doctor during the past two years? ……...……..… YES NO**
   Physician's Name: _____ Phone: _____
5. **Have you taken any medicine or drugs during the past two years? ……. YES NO**
   Are you now taking any prescription or over the counter medication? ….……..…...……. YES NO
   If yes, please list: _____
   _____
6. **Are you allergic or have you reacted adversely to any of the following? …….. ……..**

Latex	**Other Antibiotics**	**Nitrous Oxide**	**Local Anesthetics**
Sulfa	**Aspirin**	**Valium**	**(Novocaine/Xylocaine)**
Amoxicillin/Penicillin	**Codeine**	**Scopolamine**	**Sleeping Pills**
Tetracycline	**Pain Medicine**		**(Nembutal/Seconal)**

   If you answered yes to any of the above, please list: _____
7. **Are you aware of being allergic to any other medications or substance? ……..……. YES NO**
   If yes, please list: _____
8. **Circle any of the following which you have had or have at present:**

Artificial Joints (Hip, Knee)	**Emphysema**	**Cancer**	**Hepatitis A**
Artificial Heart Valve	**Cough**	**Chemotherapy**	**Hepatitis B**
Heart Murmur	**Sinus Trouble**	**Radiation Treatment**	**Hepatitis C**
Mitro-Valve Prolapse	**Asthma**	**Arthritis**	**HIV/AIDS**
Heart Pacemaker	**Tuberculosis (TB)**	**Rheumatism**	**Liver Disease**
Rheumatic Fever	**High Blood Pressure**	**Anemia**	**Yellow Jaundice**
Heart Failure	**Diabetes**	**Cortisone Medicine**	**Kidney Trouble**
Heart Disease/Attack	**Auto Immune Disorders**		**Ulcers**
Angina Pectoris	**Hay Fever**	**Hemophilia**	**Acid Reflux**
Congenital Heart Lesions	**Thyroid Disease**	**Blood Transfusion**	**Venereal Disease**
Heart Surgery	**Cold Sores**	**Epilepsy/Seizures**	**Nervousness**
Scarlet Fever	**Fever Blisters**	**Fainting/Dizzy Spells**	**Drug Addiction**
Stroke	**Glaucoma**	**Psychiatric Treatment**	**Bruise Easily**

   Has a surgeon asked you to PREMEDICATE for any of the above? ...…….……..…….. YES NO
9. **Do you have any disease, condition, or problem not listed? ……...……. YES NO**
   If yes, please explain: _____
10. **Do you or have you ever had pain in your jaw joints? ……..…… YES NO**
11. **Have you ever been told that you snore or been diagnosed with sleep apnea? ……. YES NO**
    Do you ever wake up short of breath or tired? ...……..…..……. YES NO
12. **Do you use more than 2 pillows to sleep? ……..... YES NO**
13. **Do you ever experience shortness of breath, chest pain, or become tired during normal activities? …….... YES NO**
14. **Do your ankles swell during the day? ……...……...……. YES NO**
15. **Have you lost/gained more than 10 pounds in the past year? ……...……... YES NO**

FOR WOMEN ONLY:

Are you pregnant? □ Yes □ No If yes, what trimester? _____ Are you taking birth control pills? □ Yes □ No

CONSENT: THE ABOVE INFORMATION IS TRUE

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connections with (Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection of this note. I also agree that in case credit is extended, my credit can be checked with the Credit Bureau of Idaho.

Patient, Parent or Responsible Party: _____ _____
Signature **Date**

Doctor: _____ _____
Signature **Date**